		1- For State of Maryland / De State of Maryland / De C	partment of Health and Mertificate of Death	lental Hygien	o
Physic		1. Decedent's Name (First, Middle, Last)  Eugene A. Esker		2. Date of Death Month Da September	70 14
/Medi Examii		4a. Facility Name (If not institution, give street and number) 106 E. Severn Ridge Road	4b. City, Town, or Location of Death Annapolis	40	c. County of Death  Anne Arundel
Funeral Director		5. Social Security Number  327-24-3539  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Year March 15,	9. Birthplace (State or Foreign Country) 1928 Illinois
Maryland t-f show fied at	tor	10a. State 10b. County 10c. City, Town of Maryland Anne Arundel Annapo			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
or 28s	Direc	10e. Street and Number	10f. Zip Code		itizen of What Country?
2 should be filed within 72 hours after death with the Maryland and Mental Hydene. Is marked other than "natural", or items 23a or 28a-f show sumatic event, the Madical Exeminar must be rotified at	Funeral Directo	106 E. Severn Ridge Road  11. Marital Status  1 Never Married	21409  3. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto		ted States  14. Race - American Indian, Black, White, etc.  Specify: TT.: -
Mat y faring Liz 15-0000	Completed by	3 Widowed 4 Divorced Year or Dates: 1948	acedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	ing 16b.	Kind of Business/Industry
ed with	Com	4 Ele	ectrical Engineer		iation
ntal Hy	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	n Sumame)
shoutd nd Me mark mark	To	Lawrence Esker  19a. Informant's Name/Relationship (Type, Print)  19b. M	ailing Address (Street and Number or Run	a Richards al Route Number, City	or Town, State, Zip Code)
5 분 5 분	1	Rita Esker / Wife 106	E.Severn Ridge Road	d, Annapoli	is, MD 21409
) - I 5 5		MARGINAL 21 Cremation 31 Fremoval from State	sposition (Name of crematory or other place) ry's Cemetery 9/6/0		Location - City or Town, State  apolis, Maryland
permit. Pages Department of Important: If if any Injury or o		21. Signature of Anerel Strvice Licensee	22. Name and Address of Facility John 147 Duke of Glouces	2	or Funeral Home, Inc nnapolis, MD 21401
Cate be executed /Medical Examiner the burial-transit the burial-transit the burial-transit for the burial-transit	I Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Security list can the ast fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	1 Palmonary	Fibrasis	Interval Between Onset and Death
eath certifi attending for use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
quires that the d n signed by the	by	Part II. Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	ouse contribute to the cause of death? 2 ☑ 100 3 ☐ Probably 4 ☐ Unknown
The taw requir ate has been si page 2 should	Completed			24a. Was an autopsy performed?	
Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	h (Check only one)	
I or Attending Physician: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	le of ry Murking M 1 Yes 2 No	28d. Describe how in 28f. Location (Street	
Hospital or J 24 hours after Funeral Dire tely filled in b		4 ☐ Homicide building, etc. (Specify)  29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and/c			(s) and manner as stated.
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, Day, Year)
12+		30. Name and address of person who completed cause of death (Item 23a) (Ty	1.0	Arnalo	9/5/1/6 1, MD 211/2
A 20 10 10 10 10 10 10 10 10 10 10 10 10 10	ate rar	31. Date filed (Month, Day, Year) SEP 0 5 2006 Registrar's Signature	back Highway	MINGLV	11) 11/1/2

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** AUGUST 30 2006 ROBERT 3:35 PM ENNIS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 113-18-5148 80 JUNE 07, 1926 NEW YORK Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other then "naturel", or Items 23a or 28a-f shov traumatic event, tre Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MARYLAND FREDERICK FREDERICK 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5683 CRABAPPLE DRIVE 21703 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: 2 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 SYSTEMS ANALYST U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of 1 and 2 should be ဥ JOHN ENNIS ELLEN DOWLING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MRS. SHIRLEY HOFFMASTER - DAUGHTER 2837 LEMAR STREET, SILVER SPRING, MARYLAND 20904 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō <u>=</u> Depertment of Important: If it eny injuries of page of the page of 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 9/5/2006 SILVER SPRING, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service HINES-RINALDI FUNERAL HOME, INC 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Part . Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cordiac arrest **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physicien Physician/Medical use as the ettending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred after death. Division 1 Natural 5 Pending after death.

I Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0063498 AUG. 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAOHWA, MD 400 WEST 7TH STREET, FREDERICK, MARYLAND 21701 LAKHVINDER 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State 5006 PARAMA Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 sept. 3, 9:15 Am **Physician** Eva Ruth Emas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring

Juder 1 Year | If Under 24 Hrs. 4 Saddlerock Court Montgomery Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 173-12-7113 1 M 2 TVF 90 Director Aug. 31, 1916 Ohio Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 28a-f show freumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 4 Saddlerock Court 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Item any injury or Ther treumatic event 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed by 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Social Work 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Bloom Harry Simon ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20902 11701 Stonington Place, Silver Spring, MD Ellen Emas, Daughter injury gerather t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State B'nai Israel Cemetery 09/05/06 4 Donation 5 Other (Specify) Greensburg, PA 21. Signature of Fun- al Service License 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Infarction Immediate Cause (Final **Physician** 24 Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician. Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 24 No 3 Probably 4 ☐Unknown Deem 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page ormed? 2 🐼 No certificate 1 Tes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 28c. Injury at Work? uneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death After Injury 1 XNatural s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide within 24 hours a To the Funeral C To the Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 09/03/06 D 22309 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Phillip W. Poth, M.D., 9013 Flower Ave., Silver Spring, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 06 Registrar

State of Maryland / Department of Health and Mental Hygiene 30004 1 - State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ,2006 0122 C /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Co. Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 578-54-1477 Yrs. 4-28-1943 MD 63 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or iteme 23s or 28s-1 show The Medical Examinar must be notified at Riverdale MD Prince George's 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5824 63rd Ave. 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed who.
In Hygiene.
In than "P. during most of working Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Driver Giant Foods permit. Pages 1 end 2 should be filed to Department of Heelth and Mental Hygie. Important: if item 27 is marked other tileny injury or other treumatic event. The ODG. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sterling Evans Viola Ida Taylor ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7734 Wash. Blvd. Lt #43, Elkridge, MD 21075 Richard A. Evans - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-8-06 Ft. Lincoln Cem. Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln F. H. lunn 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEUMONIA Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Examine ABlowi the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Difease Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 5 Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? à 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 Yes 2 100 1 Tyes 2 1N6 Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al м 1 Tes 2 No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Wayne Stewart Fenton

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 30005

		1- For State Registrar		Ce	rtificate	of Dea	th				Reg. No.	4	00	0 3000
Physici Medical Exam	an/	Decedent's Name (First, Midd	le,Last) W <b>a</b> y	ne S. F	ENTON					Date of De Month Septemb	Day	Year		3. Time of Death 1709 hrs
		4a. Facility Name (if not institution 11510 Old Georgetow		umber)			Town, or L nesda	ocation of	Death			County o		
Funeral Director		5. Social Security Number 060–44–2611	6. Sex	7. Age (In yrs. 53		) If Un Mon	der 1 Year ths Days	If Under Hours	24Hrs. Min.	8. Date of B				nplace (State or New York Intry)
Maryland 28a-f show any d at once.	'n	Usual Residence of Decedent  10a. State 10b. County  Maryland Montg	omery	10c. City	Rocks									10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 11602 Parkedge	Drive			10f. Z	ip Code 2085	52			10g. Citiz	en of Whate		-
r death wi or items must be	by Funeral	11. Marital Status 1 Never Married 2 MM 3 Widowed 4 Div		2 X No		If Yes, spe	dent of Hisp cify Cuban, 2 <sup>X</sup> No	Mexican,		ify Yes or N can, etc.)	ļ	14. Race White, Specify:	etc.	can Indian, Black,
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner.	ompleted t	15. Decedent's Education (Spe Elementary/Secondary (0-12)			durin		al Occupation orking life. I				İ	ind of Bus		
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be Cor	17. Father's Name (First, Middle Joseph Fento	n					R	osel	irst, Middle, yn Sha	apiro	)		
e, MD 21 I and 2 should Health and Me item 27 is ma	To	19a. Informant's Name/Relations Nancy Fenton,			1160	02 Pai	ckedge	e Dri	ve,	al Route Nu Rockv	ille,	MD	20	852
imore Pages 1 nent of H sant: If is	۱,	20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other S	pecify:	rom State	Place of Discrematory of den of	r other plac	<sub>e)</sub> e <b>mbra</b> r	nce C	09/0 emet	ery	C1	arks	-	g, MD
Balt Permit. Departi Import	O	21. Signature of tun frail ervice	/	aused the death						unera: Was espiratory ai			DC rt	20012 Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Blunt Force	e Injuries a consequence (	of):									Between Onset and Death
·.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	c	a consequence (										
cecuted 1 and - transit		events resulting in death) Last	d	a consequence (	of):									
8760, rificate be executed ng physician and as the burial - transit as the burial - transit		UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the		outcome of preg	· · _			7e				. Date of o	,	
O. Box 687 that the death certific the by the attending I detached for use as the	Physiciar	past 12 months?	LITTIVE	nant at time of d	eath 5	Petal deat		Ectopic	pregnanc	У		Month	D	ay Year
<b>b, P.O.</b> irres that the signed by the detached	by	Part II. Other significant condit	ions contributing t	o death but not	resulting in t	ne underlyii	ng cause giv	ven in Par	t I.		_		_	he cause of death? ably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed									perf 1 🗸 Yes	opsy formed?	pr de		opsy findings available ompletion of cause of S
tal Re cian: The certificate	Be	25. Was case referred to medica examiner?	Hannital:				26.Place o	Mhan -		· · · · · ·			-	<u> </u>
f Vir Physicar this	2	1 Yes 2 No 27 Manner of Death		Inpatient 2	ER/Outpat 28b. Time		DOA 28c. Injury			Home 5		nce 6	_	Scene
Division of Value of an or Attending Phers after death.  In Director: After to the in by the funeral	ation:	1 Natural 5 Pend	stigation	1. Day Year) 2006	1630 hrs		1 <b>✓</b> Y€	es 2 🔲 I	No St	Bd Describe ubject as	saulted			
Divis ospital or A hours after uneral Dire	Certification:	4 V Homicide dete	rmined (Specify)	oe of Injury - At h					11	or Town, 1510 Old	State) George	etown R	load,	Bethesda, MD
To the Hos within 24 h To the Fun	Medical	(Check only	hysician: To the be miner:Op he basis	of examination	_									
To the within To the comple	Mec	29b. Signature and title of certific	er and manner s	stated.		2	9c. License	number			29d. D	ate signe	d (Mor	th, Day, Year)
		< //	11				O.C.M	1.E.			Sept	tember	4, 200	06
15		30. Name and ad ss of poor Mary G. papple MD.	Deputy Chief	Medical Exa	miner	111 Pen	n Street,	Baltimo	ore, MD	21201				
S	tate	31. Date filed (Mo SPD Year)	7 200A 32. R	gistrar's Signat	ure	Joseph	9							

State of Maryland / Department of Health and Mental Hygiene 2006 30006 Amend items State Registrar#18 &19 per fh/9-11-06/wichd Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Moch **Physician** John Mark Filds 220 A M 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FENINSULA REGIONAL 5. Social Security Number ALCOMICO MEDICAL SAUSBUH CENTRA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month. Day, Year) 8/17/1932 7. Age (In yrs. last birthday).
74 Yrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 12 M 2□F Maryland 217-28-4893 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Delaware Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19956 USA 10930 Delaware Ave. deeth by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Pyes 2 □ No
If Yes, Give Year or Dates: AirForce 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) E.I. DuPont Co. Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental I Mari White Marie O. White Albert Fields 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Keith Kields/son 10930 Delaware Ave., Laurel, DE 19956 item 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place
Wicomico Memorial
Park Department of H importent: If its eny injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/7/06 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) ratura of Funeral Service Licenses Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 David H. Drogmod CFSF 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest 30 mm **Physician** /Medical Due to (or as a consequence of): Examiner Shack Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit widespred meteriolic Hospitel or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): Box 68760 Canar of the bloods Small Coll Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Theuncial arthree, Athrosomatic Valordor 1 Yes 2 No 3 Probably 4 Unknown Rheumeroid Lune 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No . 3007KIB 24a. Was an certificate hes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3FT DOA this After this funeral d 27. Manner of Teath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred t ☑Natural 2 ☐ Accident Injury 5 Pending To the nouse...
within 24 hours effer death.
To the Funeral Director: Aff 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge. Seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 290 Cartifier (Check only one) 29b. Signature and title fi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

M. Chael E Crand HO 105 Rat Blud Pd, St. 7, Selisbury, NO 2.84

31. Date filed (Month Qav, Yeer) DSCOLS 31. Date filed (Month Day Yeer) 6 2006 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Bayer St. Spart

AMEND#1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legi Amend Items 25 27 28a-f per ME C859 09/21 AMEND#23aPart II State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar PER PHY. 7/21/06 AACO HEALTH DEPT. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elizabeth Ann Fox Month Year Physician ELIZ ABETH 15 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 30, 1913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F 92 Austria Yrs Aug. 287-52-1911 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ 715 Benfield Road 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 ò 1 Yes 2 XNo Specify: þ 3 ₩ Widowed 4 Divorced "natural", leted 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) be filed within 7 al Hygiene. Comp College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fit and Mental H Mathias Konrad Ernestine Engels . Pages 1 and 2 should b thent of Health and Ments tant: If Item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Fox/Son 1165 River Bay Road Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) July 19, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** HOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exami CENTERCATION APPROVED BY MEDICAL EXAMINES. Due to (or as a consequence of) Box 68760 ettending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month Day Year 4□ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use combute to the cause of death? Records, ģ MENTIA 2 No 1 Tes 3 Probably 4 Unknown Completed Per 70WSION, Left Hip Fracture with Repair 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? FRACTURE WITH PEPAIR Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 XYes ZENO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending atural 5 Pending To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A 3:40 a M Subject fell 1 ☐Yes 2 No investigation 06/26/2006 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide MD 715 Benfield Rd., Severna Park Assisted Living Facility 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 046360 of death (Item 23a) (Type, Print) DTEPARSHIGHMAY MILLERSVILLE MD 21108 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1 9 2000

			For State Registrer		State of	Marylan		rtment of tificate of		d Mental H	ygiene2	106	30008
	Physici /Medio Examin	cal	4a. Facility Name (If no	YWARD t institution, gi	FORBES, S	oer)		4b. City, Town,	or Location of Do	2. Date of I Month $\hat{O}$	30 4c. Cour	Year 2006 ity of Death	3. Time of Death
	Funeral Director		5. Social Security Number 241–32–368	88			last birthday) Yrs.	If Under 1 Year Months Days		Aug 2		9. Birthp NOR'I	olece (State or Foreign TH CAROLINA
	with the Maryland s or 28a-f show	ctor	MD	0b. County <b>TAL</b>	вот	10c. Cit	y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes XXNo
	th with th	Funeral Director	10e. Street and Number 10486 FOR		RDEN ROAI	)		10f. Zip Code 21	625		10g. Citizen o	f What Cour	ntry?
H.	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "neturel", or Iteme 23a or 28a-f show event, the Medical Examinar must be notified at	d by Funer	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Deced Armed Forc 1 XYes 2 If Yes, Give Year or Date	□ No		Vas Decedent of Yes, specify Cui ☐ Yes 2 X No		(Specify Yes or Nuerto Rican, etc.)	14. R 8. Spec	ace - Americ lack, White, sify: WHI	etc.
$S_{\mu} E N O C H$ Maryland 21215-003	thin 72 h e. en "netu Medica	Completed by	15 (Specify of Elementary/Seconda		ducation rade completed) College (1-4	or 5+)	16a. Deced (Give life. L	lent's Usual Occu kind of work done DO NOT use retir	ipation a during most of ad)	working	16b. Kind of	Business/Ind	dustry
ENOCH land 21215	filed will Hygien other th	Ве Соп	7 17. Father's Name (Fire		0		CAR	PENTER	18. Mother's f	Name (First, Midd		TRUCTI	ON
N Pag	should be ind Mental i marked o	To B	JESSE SPR				105 14-00-	- Add /C4		DDIE B.	-	- 01-1- 77-	2.41
	and 2 si salth and n 27 is r		GERVIOS WO				1048	6 FORES		Rural Route Num			
FORBE Baltimore,	Peges 1 ent of He nt: If iter ry or oth		20a. Method of Disposi 1 ☐ Burial 2 💥 0 4 ☐ Donation 5 [	remation 3 (	□Removal from St	ate C	emetery, cren	sition (Name of natory or other place)  E CREMA'		Date 9/2/200	20c. Location	-	wn, State
F01 Balti	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, I'm Meonce.		21. Signature of Funer		ensee	-541 C =	22	. Name and Addr	ess of Facility	IN & NEW			
	Physician		23a. Part 1. Enter the c shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)			ised the deat th line.	h. Do not ente	er the mode of dy	RRISON S	T EASTON diac or respiratory	• MD 21 arrest,	601	Approximate Interval Between Onset and Death
	/Medical Examiner			ions	Due to (or	as a conseq	uence of):						,
2	cuted nd ransit	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or injuthat initiated events		Due to (or	as a conseq	uence of):						
38760,	icate be executed physicien and s the burial-transIt	cai	resulting in death) Last	l	Due to (or	as a conseq	uence of):						
.O. Box 68	Attending Physician: The lew requires that the death certificate be executed in death. •ctor: After this certificate hes been signed by the attending physicien and by the funeral director, pege 2 should be deteched for use es the burial-transit	Completed by Physician/Medi	IF FEMALE:  23b. Was decedent proving the past 12 mo 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?		h 2 ∏ Feta nt at time of d	I death 3	Ectopic pregnand Other (specify)	су			ate of delive	ory Day Year
ds, P	signed to	d by P	Part II. Other significan	nt conditions	contributing to dea	th but not res	ulting in the ur	nderlying cause g	iven in Part I.		l tobacco use co ] Yes 2 □ No		abity (Disknown
Division of Vital Records, P.O.	The lew require ete hes been sig pege 2 should b	Somplete		701	7					24a. Wa aut per	formed?	were autoperior to condeath?	psy findings available inpletion of cause of
Vita	Physician: The le r this certificete hes ral director, pege 2	Be	25. Was case referred examiner?	to medical	Hospital:			-5		Death (Check only	one)		
sion of	ttending Physical death.	Certification; To	27. Manner of Death 1 Alaturat 5 2 Accident	☐ Pending investigation	28a. Date of (Month,		28b. Time of Injury	28c. Inju	4   Nursin	g Home 5 Re 28d. Describe	sidence 6 🗆 O		/)
Divis	af or Att	Sertific	3 ☐ Suicide 6 4 ☐ Homicide	G Could not to determined	286. Place of	Injury - At he , etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office		28f. Location City or T	(Street and Num own, State)	nber or Rura	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 (Check only one)	Øertifying P Medical Exa	hysician: To the b miner: On the bas and manne	is of examina	wtedge, death tion and/or inv	occurred at the testigation, in my	ime, date and pla opinion, death or	ace, and due to th ccurred at the time	e cause(s) and r e, date and place	manner as st e, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title	ofcertifier	allan	١	ND	29c. Licer	se number	7/19	29d. Date sign		0 200 G.
	-\		30. Name and address	The same	completed cause	of death (Iten	n 23a) (Type, I	Print)	) > (	141	4444	313	0 2006.
	ナリナ Sta	to.	31. Date filed (Month, I	Day, Year)	NATHAN M.	D. 219		HINGTON	ST EAST	ON, MD 2	1601		
	Registr		AU	G 3 1	2006	1000 d							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 2006

		For State Registrar	e (First, Middle, Last		aryland / Depa <i>Cel</i>	rtificate of L	Death		g. No.	3. Time of Deat
<b>Physicia</b>								Month	Day Yea	
/Medic	al		d A. Fowle			4h City Tourn or	Location of Death	Sept. 3,	2006 4c. County of D	7.04
Examin	er		f not institution, give							
			od Parkpla		e (In yrs. last birthday)	Bethesda If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgome 9.	Birthplace (State or For
uneral		5. Social Security N	18	M 2□F	Vrc	Months Days	Hours Min.	(Month, Day, Jan. 25,	Year)	ew York
irector	-	006-30-78			76			Jan. 23,	1930 IN	ZW IOIK
A ==	-	10a. State	10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lin
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show importent: If item 27 is marked other then "natural", or items it in the individual other than items in the individual once.	ō	MD	Montgome	1417	Bot	hesda				1y∑Yes 2□
288	Director	10e. Street and Nu		ELY	Бес	10f. Zip Code		1	0g. Citizen of What	Country?
a or	ā	9707 01	d Georgeto	own Road	Suite 2206	20814	<b>\</b>	τ	nited Sta	ates
ns 2	Funeral	11. Marital Status	u occige c	12. Was Decedent		Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		American Indian, Vhite, etc.
The state of the s	Fu		ied 2x7xMarried	Armed Forces? 1 ☐ Yes 2 ☑				riioari, etc.)		
0,1	by	3 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	wnite
eal E	Completed		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Busine	ess/Industry
u di	ple	Elementary/Sec	ondary (0-12)	College (1-4or	`life.	DO NOT use retired	1)		I.I.S.T.	
a nyglelle. I other then " vant, I've Me	E O	Lighter that y/ Cook	strately (o 12)	5+		ysicist _				
othe ant,	Be C	17. Father's Name	(First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame)	
ked ic	To B	Robert	H. Fowler				Carolyn A	-		
T Terr	_	19a. Informant's N	lame/Relationship (7	урв, Print)		ing Address (Street				
27 ls		Shirley	Fowler /	Wife	9707	01d Georg	getown RD	#2206 E	Bethesda,	MD 20814
2 E E		20a. Method of Dis			20b. Place of Disp	osition (Name of ematory or other place	201	Date	20c. Location - City	y or Town, State
الله الله			☐ Cremation 3 🔀 5 ☐ Other (Specify		)	Cemetery	'09711	1/06 K	alamazoo	, Michigan
njur.		_	uneral Service Licen			22. Name and Addre				
any i		1/1/1/	1 8	K		5130 Wisco		-		
ledical aminer	ner	Sequentially list of any, leading to cause. Enter Unc	onditions, mmediate teriving	b	s a consequence of):					
sician and burial-transit	Examine	Cause (Disease of that initiated even resulting in death)	lS	cDue to (or a	s a consequence of):					
ite has been signed by the attending physici bage 2 should be detached for use as the bu	dicai		•	d						
ed by the attending physic detached for use as the b	by Physician/Medic	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	2 months?		2 Fetal death 3	☐Ectopic pregnanc	у		23d. Date o Month	
68	d by Pł	Part II. Other sign	ificant conditions	ontributing to death	but not resulting in the	underlying cause gr	ven in Part I.			ite to the cause of deat ☐ Probably 4 ☐Unk
been si should	Completed							24a. Was		re autopsy findings ava
S S	mp								rmed? dea	or to completion of cause th? Yes 2□ No
P 9							on Plant of Dan			1165 20140
cate ha	e	25. Was case ref examiner?		Hospital:		Ott	hor	th Check onl		(Spacify)
sertificate ha ector, page	0	1 ☐ Yes 2f		1 ☐ Inpa 28a. Date of Ir		ent 3 DOA	4 Nursing n		dence 6 Other	
this certificate has al director, page 2	ို	07 14-0	atti	(Month, L	Day Year) Injury	/ Wo	rk? ]Yes 2□No			
After this certificate hauneral director, page	ို	27. Manner of De 1	5 Pending						Street and Number	
After th funeral	ို		5 Pending investigation	e 28e Place of	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (. City or To	wn, State)	or Rural Route Number
After th funeral	ို	1 ☑Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigation 6 Could not be determined	28e. Place of building,	etc. (Specify) st of my knowledge, de	ath cooured at the t	ime date and place	City or To	cause(s) and mann date and place, and	er as stated.  d due to the cause(s)
After th funeral	0	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	5 Pending investigation 6 Could not be determined	28e. Place of building,	etc. (Specify) st of my knowledge, de	ath occurred at the t investigation, in my	ime date and place	City or To	cause(s) and mann	er as stated. d due to the cause(s)
fter death. Director: After th in by the funeral	ို	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	5 Pending investigation of Could not be determined.  1 Certifying Place of Certifying	28e. Place of building, nysicien: To the beminer: On the basis and manner	etc. (Specify) st of my knowledge, de	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	City or To	cause(s) and mann date and place, and	er as stated.  d due to the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink Pak Chung Fan State of Maryland / Department of Health and Mental Hygiene 30010 2006 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day August 31, 2006 0953 hrs **Medical Examiner** CHEUNG 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death **Baltimore County** 825 Dulaney Valley Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Foreign Days Months Hours Director Country) China 1937 215.76.6986 69 April 6, 1X M Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location any 10a State 1 Yes 2 X No or 28a-f show Baltimore, MD 21215-0036

Jennit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other trannatic event, the Medical Examiner must be notified at once. Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Ö 10 Jessie Court 21136 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' Never Married 2 X Married 2 X No Yes Asian Specify If Yes. Give Year 1 Yes 2 X No specify: Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Chinese Restaurant Entrepreneur 2 years 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Yiu Kwon Fung Be Ming Fan Tat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Jessie Court, Reisterstown, Maryland 21136 Shui King Fan/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 09/05/2006 Rockville, Maryland Parklawn Mem. Park Donation 5 Other Specify Signature of Funeral Service Licenses 22 Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval **Physiciar** Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical ned by the attending physician detached for use as the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Completed s been si should b 24a Wasan 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? 2 No Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 26.Place of Death (Check only one) 25 Was case referred to medical funeral director. Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 After this ٩ 1 Yes No 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification Subject jumped from parking garage FOUND Natural Yes 2 V No Pending the Funeral Director: Aug 31, 2006 0945 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be determined (Specify) Sidewalk 825 Dulaney Valley Road, Towson, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OCME. September 1, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D.

State

Registrar

31. Date filed (Manth Pay,

32. Registrar's Signature

TOMPLAR

2006

State of Maryland / Department of Health and Mental Hygiene 006

Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2006 **Physician** 10:45 PM SHAWN EARL FRASE Sept. 10 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 24063 Friendship Road Preston Caroline 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 8, 1 Birthplace (State or Foreign Country) 6. Sex 1M M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 37 Yrs 219-90-7503 1969 New Jersey Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No MD Preston Director Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24063 Friendship Road 21655 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏝 No If Yes, Give Year or Dates: filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, QMES. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Earl E. Frase Judith Hobby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24063 Friendship Road Earl E. Frase/Father Preston, MD 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jr. Order Cemetery 9/13/2006 Preston, Maryland of Funeral Service Loans 22. Name and Address of Facility 21. Signatur Framptom Funeral Home, PA-Federalsburg, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hypercaphele **Physician** Chronic 10 415 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) ete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes ofter death.

Director: After this certification in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 Yes 2 PNo Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled 24 hours e 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 MD 9/13/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dutchman's Ln Easton MB 21601 Whitesel MD 505A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

14

SEP

State of Maryland / Department of Health and Mental Hygiene For State Registrar 30012 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 23:20M Robert A. Fowler 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1**≅**M 2□F Yrs Sept. 28, 1937 Virginia 226-42-9472 68 Director Usual Residence of Decedent e filed within 72 hours after deeth with the Maryland at Hygiene. other then "netural", or Iteme 23a or 28a-1 ehow 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or then "netural, or Iteme 23s or 28s-f ehow Its Medical Examiner must be notified at 1 Yes 2 No Laurel DE. Sussex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 19956 12927 Alex Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professional Dog Handler 12 Dogs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipiry or other treumatic event 9008. Joseph Anthony Fowler Edna Mae Ballenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane T. Fowler (Wife) 12927 Alex Avenue Laurel, DE 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Crematory of Delmarva 08-31-2006 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home Short-Vewe in 13 E. Grove St. Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SCV **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed cenificete 2 No 2. No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient မှ 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending within 24 hours after deeth. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation M 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) Simona Eng D.O. IOOE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 2006 Registrar

Please Type or Print in Black Indelible Ink Raymond John Gift State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day September 4, 2006 Medical Examiner Raymond John Gist 2115 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 733 Sligo Avenue, Apt. 201 Silver Spring Montgomery 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8 irth (MM/DD/YYYY) 9. 8 irthplace (State or **Funeral** ForeigMashington, CountryDC 218-66-5269 Months Days Director Hours 1955 1 X M 50 Sept. 24, Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. Yes 2 X No Maryland Montgomery hours after death with the Maryland Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 733 Sligo Avenue, Apt. 201 20910 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married White, etc. of Health and Mental Hygiene.

If item 27 is marked other than "natural", or i Yes 2 x No 4 X Divorced Widowed If Yes, Give Year Yes 2 X No specify: White Specify or other tranmatic event, the Medical Examiner à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1 and 2 should be filed within 72 MD 21215-0036 4 Lab Technician N.I.H. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John David Gist Virginia Baker Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Gist/ Father 3712 Everton Street, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, Date 1 X 8urial 2 Cremation 3 Removal from State crematory or other place) September 8 Parklawn Memorial Park Donation 5 Other Specify 2006 Rockville, Maryland Prancis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 2090 Physician art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Gastrointestinal Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Chronic Alcohol Use Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and for use as the burial - transi ian/Medical item#1,perme,g860, 10/6/06 TI X AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death Physic Other (Specify) Yes 2 No 9 Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene After this 2 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending Fo the Funeral Director: in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. ature and title 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E September 5, 2006 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mostle Pay, Year) 32. gistrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 2, 2006 1315 EDMUND BERNARD GALLAGHER, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT 6170 OCEAN GATEWAY TRAPPE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F PA Yrs. DEC 8, 178-30-5306 Director Usuaf Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10h County 10c. City, Town or Location or 28a-f show other treumetic event, it is Micrical Examinar must be notified at 1 ☐ Yes 2 X No TRAPPE Director TALBOT MD 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mental Hygiene. snt: If item 271s marked other than "neturel", or Items 23a or 2 21673 6170 OCEAN GATEWAY Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 I If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**io Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION TRUCK DRIVER 0 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JEAN CATHERINE BOCK EDMUND B. GALLAGHER ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6170 OCEAN GATEWAY, TRAPPE, MARYLAND 21673 MARIE GALLAGHER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō = 6 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. WHITE MARSH CEMETERY 9/6/2006 TRAPPE, MARYLAND \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERA 200 S. HARRISON ST EASTON, MD 21601

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HELFENBEIN & NEWNAM FUNERAL HOME PA Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician Myocardia years /Medical Due to (or as a consequence of) **Examiner** ovonany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner rsician and 9 burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician a Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۵ 1 Xves 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ပ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 PURDY ST., EASTON, MD 21601 MARY DESHIELDS M.D. 32. Registra Signature State 2006 Registrar

			Please 1	ype or Prin						•	_	ible.	
			1 - For State	State of Ma	aryland.	•	rtment of F tificate of		and M		1ene 93. No.2 ()	0.5	30015
13		X	Registrar     Decedent's Name (First, Middle, Last)				inoute or	Douth	1	2. Date of Deat	h	3	3. Time of Death
	Physici /Medic		AUBREY FRED GO	ODWIN, JI	R.					Septemb	er 2	2006	1735 "
	Examin		4a. Facility Name (If not institution, give	street and number)	/ 1		4b. City, Town, o	or Location of	f Death		4c. County	of Death	
			1 he Memoria 5. Social Security Number 6. Sec	HOSP	rital	hinth days)	FAS If Under 1 Year	If Under 2	24 Hrs	9. Date of Righ	TA	LBU	e (State or Foreign
€9	Funeral Director		219-70-8758	M 2□F	48	Yrs.	Months Days	Hours	Min,	8. Date of Birth (Month, Day) OCT 22,	1957	Country) MARYI	
	aryland ehow	J.	Usual Residence of Decedent  10a. State 10b. County		10c. City, T							10d.	Inside City Limits  1X Yes 2 □ No
	the M	Director	MD TALE  10e. Street and Number	SOT		OXFO	RD 10f, Zip Code			1	On Citizen of	What Country	
	Sa or		903 S. MORRIS ST	•				21654			9. 020 0.	USA	
	death	Funeral		12. Was Decedent Armed Forces?			Vas Decedent of I Yes, specify Cub	Hispanic Orig				ce - American ck, White, etc.	
020	hours after death with the Maryland turet; or Iteme 23a or 28a-f ehow at Exeminant be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:			Yes 2X No		, ( 0010)	ritoari, etc.)		WHITE	
200-c	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	1	(Give I	ent's Usual Occup	during most	t of workii	ng	16b. Kind of B	usiness/Indus	try
717	d within giene. or then	Completed	Elementary/Secondary (0-12)	College (1-4or s	5+)		OO NOT use retire ECTRICIA	•			HOME I	MPROVEN	MENT
and	id be file ental Hy ked oth	To Be	17. Father's Name (First, Middle, Last)  AUBREY F. GOODWIN	I. SR						(First, Middle, i	Maiden Sumai	ne)	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Ty			19b. Mailin	g Address (Street	and Numbe	r or Rura	l Route Number	City or Town	, State, Zip Co	ode)
Σ,	and 2 Balth in 27 I		AUBREY F. GOODWIN	I, SR./FA	_		OX 34, 0	XFORD,					
Hore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 271s marked other than *naturet*; or iteme 23a or 28a*f show any fujury or other traumatic event, It a Madical Examinational bandone.		20a. Method of Disposition  1 Aurial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	cem	etery, crem	sition (Name of natory or other pla METERY		9/8/2			- City or Town	
galt	epartn sports ny inju		21. Signature of Funeral Service Licens			22	Name and Addre			& NEWNA			
_	g0239		23a. Part1. Enter the disease, or compl	Justi C.f.		20	OS. HAR	RISON	ST	EASTON,	MD 216	01	oproximate
	Physician /Medical Examiner  private private it ausit	icai Examiner	shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Facuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequent	ice of):	1 Hated	Chola	engii	Scarcer	noma	) Ör	terval Between nset and Death
O. Box 68	w requires that the death certificate be executed been signed by the attending physicien and should be datached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 T5 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3	Ectopic pregnand Other (specify)	;y				ate of delivery onth Da	ıy Year
ds, r	requires that the neen signed by th hould be datache	by	Part II. Other significant conditions con	ntributing to death b	out not resulting	ng in the ur	nderlying cause gr	ven in Part I.					cause of death?
Kecords,	e law req has been je 2 shou	Completed	ly pertensi o	w'			<del></del>			24a. Was a autops	y	Were autopsy prior to compl death?	r findings available letion of cause of
	n: Th ficate n: pag	e Co	25. Was case referred to medical		·		<del> </del>	20.01	(5	1 ☐ Yes	25 No		<b>⊉</b> No
VItal	s cert	0 8	examiner?	Hospital:	ent 2□EB	VOutpatien	t 3 DOA Ot	hor		n <i>(Check only</i> on me 5 ☐ Reside		ner (Specify)	
on or	iding Phy th. After this funeral of	-	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	Jry 28	Bb. Time of Injury	28c. Inju		:	28d. Describe h			
UIVISION	after dea Director	Certification:	3 Surcide 6 Could not be 4 Homicide determined	28e. Place of In building, el	jury - At home tc. (Specify)	e, farm, stre	eet, factory, office			28f. Location (S. City or Town		ber or Rural R	oute Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funers! Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier 1 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner st	of examination	edge, death	occurred at the trestigation, in my	ime, date and opinion, deal	d place, th occurr	and due to the c	ause(s) and m ate and place,	anner as state and due to the	ed. e cause(s)
	o the	Me	29b. Signature and title of certifier		2100.		29c. Licen	se number		2	9d. Date signe	ed (Month, Da)	y, Year)
	->-0		Dea Vet	ت			7	(2411	TH		0910	2106	
	4-		30. Name and address of person who co				Print)	Eanh	w	HD ZI	601		-
1000	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 5 20	32. Regist	rar's Signatur		and a						
					where the same of	-							

State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 5:10 August Glenn Lee Gabell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Future Care Chesapeake Anne Arundel Arnold Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs 5/11/1942 64 Maryland 219-76-3660 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 'naturel', or Items 23a or 28a-f show injury or other treumatic event, the Medical Exeminer must be notified at 1 Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 914 Preserve Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No .lf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: if Item 27 is marked other then "naturel; or Item eny injury or other treumetic event, the Medical Exeminer ance. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Disabled N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George T. Gabell Gladys E. Meir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Gabell, Sr./Brother 914 Preserve Drive, Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)
21. Signafur of Fig. 1 Kalas Crematory 9/1/2006 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enfer the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ours Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or se a noneequarine of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 has 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: s after death.
I Director: After this cent in by the funeral dire Cther: ပ္ ursing Home 1 Yes 2 70 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death

1 Death

2 Accident 28c. Injury at Work? 28a. Dafe of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral L completely filled 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ferans Huy Millers ville MD 21108 State Registrar

Cesar-Noe Gomez Gonzalez

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 30017

		Registrar		• • • • • • • • • • • • • • • • • • • •		Death			Г	Reg. No.			
Physici		1. Decedent's Name (First, Midd						2	. Date of Dea	ath Day	Year		e of Death
dical Exami	iner	Cesar Noe	Gomez Gon	zalez					Septemb	er 2, 20	006	20	18 hrs
		4a. Facility Name (if not instituti RT. 40 & Winters Lai	=	umber)	4	b. City, Town, or I Catonsville	ocation of	f Death			County of altimore		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under	r 24Hrs.	8. Date of B	irth(MM/D	D/YYYY)	9. Birthplace	(State or
Director		none	1 M 2 F	25	Yrs.	Months Days	Hours	Min.	May 2	9, 19		Foreign Country)E	1 Salvad
w any		Usual Residence of Decedent  10a State 10b. County		10c. City,	Town or Location	on							nside City Limits
Maryland 28a-f show	ō	Maryland Balti	nore	Wind	lsor Mi							Δ	Yes 2 No
5-0036 led within 72 hours after death with the Maryland hygiene. other than "natural", or items 23a or 28a-f sho the Madical Examiner must be notified at once.	Director	10e. Street and Number 31 Flagstone				10f. Zip Code	1133				en of Wha L Sal	t Country? vador	
with ns 23 be no	ıral	11. Marital Status		cedent Ever in U.S		Decedent of His	oanic Orig			lo- 1		American Inc	ian, Black,
ter death	Funeral	1 X Never Married 2 N	farried Armed F 1 Yes vorced If Yes, Give Yes	2 X No		es, specify Cuban,			dorian	n s	White,	eic. Hispa	nic
2 hours after "natural",   Examiner	d by	15. Decedent's Education (Spi	or Dates:		16a. Decedent	's Usual Occupati	on (Give k	ind of wo	rk done			ness/Industry	
72 hor	ompleted	Elementary/Secondary (0-12	College (	1-4 or 5+)	during mo	st of working life.	DO NOT	use retire	d)				
21215-0036 suld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	ldπ	Unknown			Mechan	nic				Pr	ivat	e	
5-00 led wit Hygien other the N	S	17. Father's Name (First, Middle	e, Last)			1			irst, Middle,	Maiden S			
21215-0036 Muld be filed within 72 Mental Hygiene. marked other than 'cevent, the Medical	Be	Moises Gonz					Mari		Gom			illa	
	မ	19a. Informant's Name/Relation				Address (Street							ode)
ore, MD 2 es 1 and 2 shou of Health and N If item 27 is n		Moises Gonzal  20a. Method of Disposition	ez / fath			Gumwood tion (Name of cen			Date			City or Town,	State
nore, MD 2 ages 1 and 2 shou nt of Health and N it: If item 27 is n other traumatic		1 Burial 2 Crematic	n 3 📈 Removal fi	rom State C	rematory or oth	er place)	- 1						
Fag ment tant: or of		4 Donation 5 Other 5	Specify:	Sar		1 Cemete	-			6 Sar	n Mig	uel, E	1 Salva
Baltimore, permit Pages I as Department of He Important: If ite		21. Signature of Funeral Service	A mana			ame and Address pe Funer							
Physician	90 9	Zarry 1. 23a. Part I. Enter the disease, of	r complications that of	aused the death.	Do not enter th	38 Mar1b	oro I	Pike	Fores espiratory ar	rest shoc	le, M	d. 207	47 oximate Interval
		failure. List only one caus	. 12							,			
/Medical	11 //		I I a and I and the									Betv	veen Onset and Death
xaminer	ľ	Immediate Cause (Final diseas or condition resulting in death)	e a Head Injur	ies								Betv	veen Onset and Death
		Immediate Cause (Final diseas or condition resulting in death)	e a Head Injur									Betv	
	ner	Immediate Cause (Final diseas or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a b.	ies	):							Betv	
	aminer	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase of high yearth initiate)	Due to (or as a c.	ies a consequence of a consequence of	):							Betv	
xaminer	Examiner	Immediate Cause (Final diseas or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c.	ies a consequence of	):							Betv	
Examiner		Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase of high yearth initiate)	Due to (or as a b.  Due to (or as a c.  Due to (or as a c.	ies a consequence of a consequence of	):							Betv	
xaminer		Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or hijbry that hithors devents resulting in death) Last  UNPENDED  IF FEMALE:	b. Due to (or as a b. Due to (or as a c. Due to (or as a d. AMENDED	ies a consequence of a consequence of	):					23d.	Date of d	Betv	
xaminer	n/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of highly that highest events resulting in death) Last  UNPENDED	b. Due to (or as a d  d.  AMENDED  AMENDED  23c. If yes, 1  Live	a consequence of a consequence of a consequence of outcome of pregribirth	): ): ): anancy 2	al death 3 [	Ectopic	pregnanc	1			Betv	
xaminer	n/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or hijbry that hithors devents resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	b. Due to (or as a b. Due to (or as a d. Due to (or	a consequence of a consequence of a consequence of outcome of pregribith nant at time of dea	); ); ); hancy 2		Ectopic		1		Date of de	Bety	Death
xaminer		Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of highly that highest events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	Be a Head Injuri Due to (or as a b) Due to (or as a c) Due to (or as a d) AMENDED  23c. If yes, 1	a consequence of a consequence of a consequence of outcome of pregribirth nant at time of deal	): ): ): anancy 2	al death 3 [ ner (Specify)		pregnand	ey e	1	Date of do	Bety	Peath Year
xaminer	by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijbry that hithats J events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	Be a Head Injuri Due to (or as a b) Due to (or as a c) Due to (or as a d) AMENDED  23c. If yes, 1	a consequence of a consequence of a consequence of outcome of pregribirth nant at time of deal	): ): ): anancy 2	al death 3 [ ner (Specify)		pregnand	cy 23e. Did	tobacco u	Date of di Month	elivery	Year se of death?
xaminer	by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of highly that highest events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	Be a Head Injuri Due to (or as a b) Due to (or as a c) Due to (or as a d) AMENDED  23c. If yes, 1	a consequence of a consequence of a consequence of outcome of pregribirth nant at time of deal	): ): ): anancy 2	al death 3 [ ner (Specify)		pregnand	cy 23e. Did	tobacco u	Date of di Month	elivery Day  ute to the cau Probably ere autopsy fi	Year  se of death?  Unknown
xaminer	by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of highly that highest events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	Be a Head Injuri Due to (or as a b) Due to (or as a c) Due to (or as a d) AMENDED  23c. If yes, 1	a consequence of a consequence of a consequence of outcome of pregribirth nant at time of deal	): ): ): anancy 2	al death 3 [ ner (Specify)		pregnand	23e. Did 1 Yo 24a. Wa: perf	tobacco uses 2 🗸	Date of do Month  No 3  24b. We private of the second of t	elivery Day  ute to the cau Probably ere autopsy fi	Year se of death?
xaminer	Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursaase or hijbry that hithors a events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond	b. Due to (or as a b. Due to (or as a d. Due to (or as a d. AMENDED  23c. If yes, 1 Live 4 Preguents anknown 9 Unknown 10	a consequence of a consequence of a consequence of outcome of pregribirth nant at time of deal	): ): ): anancy 2	al death 3 [ ner <i>(Specify)</i> nderlying cause g	iven in Pa	pregnand	23e. Did 1 Yu 24a. Wa: auto perf 1 Yes	tobacco uses 2 🗸	Date of do Month  No 3  24b. Wording	elivery Day  ute to the cau Probably ere autopsy fro to complet	Year  se of death? 4 Unknown
Examiner	Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury triat hittate J events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond	a Head Injuring Due to (or as a b).  Due to (or as a c).  Due to (or as a c).  Due to (or as a c).  AMENDED  23c, If yes, 1	a consequence of a consequence of a consequence of outcome of pregnibirth nant at time of dealown to death but not re	): ): nancy 2  Fet ath 5 Oth	al death 3 [ ner (Specify) nderlying cause g	of Death (	pregnand rt I.	23e. Did 1 You 24a. Was auto perf 1 Yes	tobacco uses 2 🗸	Date of do Month  No 3  24b, We pride	elivery Day  ute to the cau Probably ere autopsy fro to complet ath? Yes	Year  Se of death?  Unknown Indings available on of cause of  No
xaminer	To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (U sease of highly that highest 2 events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond  25. Was case referred to medic examiner?  1 Yes 2 No	b. Due to (or as a b. Due to (or as a d.  AMENDED  AMENDED  1 Live 4 Preguentations contributing to the contributions and the contributions are contributing to the contributions are contributions.	a consequence of a consequence of a consequence of outcome of pregnoutcome of pregnoutcome of death out not reconsequence of things of the consequence of the consequ	): ): nancy 2	al death 3 [ ner (Specify)  Inderlying cause g  26.Place 3 DOA	of Death (	rt I.  (Check or	23e. Did 1 Yu 24a. Wa: auto perf 1 Yes	tobacco u es 2 🗸	Date of do Month  No 3  24b, We pride 1  Ance 6	elivery Day  ute to the cau Probably ere autopsy fro to complet ath? Yes  Other Scene	Year  Se of death?  Unknown Indings available on of cause of  No
xaminer	To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or highly that highest events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond  25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death	a Head Injuring Due to (or as a beautiful beau	a consequence of a consequence of a consequence of a consequence of outcome of pregnibirth nant at time of dealown to death but not related to the consequence of Injury by Day, Year)	p:    Petath   S   Oth	al death 3 [ ner (Specify)  Inderlying cause 9  26 Place 3 DOA   njury 28c. Injury	of Death (	rt I.  (Check or Nursing ?	23e. Did 1 You 24a. Was auto perf 1 Yes  lly one)  Home 5  8d. Describe	tobacco u es 2 🗹 s an opsy ormed? 2 No Residen	Date of do Month  Se contribution  24b. Working the second of the second	elivery Day  ute to the cau Probably ere autopsy fro to complet ath? Yes  Other Scene	Year  se of death?  Unknown  Indings available on of cause of  No
xaminer	To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that highest events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond  25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Per 10 Natural 1 Natura	a Head Injuring Due to (or as a b).  Due to (or as a c).  Due to (or as a c).  Due to (or as a c).  AMENDED  23c. If yes, 1	a consequence of a consequence of a consequence of a consequence of outcome of pregnibirth nant at time of dealown to death but not related to the consequence of Injury by Day, Year)	p:    p:   p:   p:   p:   p:   p:   p:	al death 3 [ ner (Specify)  nderlying cause g  26 Place 3 DOA  njury 28c. Injury 1 Y	of Death (Other, y at Work'es 2	rt I.  (Check or No C	23e. Did 1 Yes 24a. Was auto perf 1 Yes ily one) Home 5 3d. Describe	tobacco u es 2  popsy formed? 2 No Residen how injur of vehic	Date of do Month  No 3  24b. We produce 1  and a control of the co	elivery Day  ute to the cau Probably ere autopsy fror to complet ath?  Yes  Other Scene	Year  se of death?  Unknown  Indings available on of cause of  No
xaminer	To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or highly that highest events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond  25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Per Condetted Condetted  3 Suicide 6 Condetted  1	a Head Injurinue to (or as a beta beta beta beta beta beta beta be	a consequence of a consequence of a consequence of a consequence of outcome of pregnounce of pregnounce of a consequence of pregnounce of pregnounce of the consequence of the consequen	ER/Outpatient 28b. Time of Ir FOUND: 2012 hrs 2012 hrs 2012 nr, stree	al death 3 [ ner (Specify)  nderlying cause g  26 Place 3 DOA  njury 28c. Injury 1 Y	of Death (Other, y at Work'es 2	rt I.  (Check or ) Nursing ?  No C	23e. Did  1 Ye  24a. Wa: auto perf  1 Yes  Ily one)  Home 5 8d. Describe ccupant of the coupant	tobacco u es 2 🖋 s an ppsy formed? 2 No Residen how injur of vehic (Street an State)	Date of di Month  No 3  24b. We pring de 1  The prince 6   The prince of	elivery Day  ute to the cau Probably ere autopsy fror to complet ath? Yes  Other: Scene of the colling or Rural Router autopsy from the colling of Rural Ru	Year  Se of death?  Unknown Indings available on of cause of  No  Sion  te Number, City
Division of Vital Records, P.O. Box 68760, Spital or Attending Physician: The law requires that the death certificate be executed to choices after features. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursass or in jury it at hithers I events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9  Ur  Part II. Other significant cond  25. Was case referred to medice examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Per Cartifician Suicide 6  Co det  4  Homicide  29a. Certifier 1  Cartifician death)	a Head Injuring Due to (or as a below belo	a consequence of a consequence of a consequence of a consequence of outcome of pregrabirth mant at time of dealers of linjury by Day, Year)  Inpatient 2	ER/Outpatient 28b. Time of Ir FOUND: 2012 hrs 2014 Highway	al death 3 [ ner (Specify)  Inderlying cause g  26 Place 3 DOA   Injury 28c. Injury 1   It, factory, office b	of Death (Other,4 y at Work'es 2 viulding, etc.	Check or Nursing C C R	23e. Did  1 Yes  24a. Wa: auto perf  1 Yes  Bd. Describe occupant of  8f. Location or Town, t. 40 & W	tobacco u es 2  s an ppsy 2 No Residen Residen Residen (Street an State)	Date of do Month  No 3  24b. Wording de 1  Try occurred in volvind Number  Lane, Ca	elivery Day  ute to the cau Probably ere autopsy fror to complet ath?  Yes  Other Scene ded or Rural Rou attonsville,	Year  Se of death?  Unknown Indings available on of cause of  No  Sion  te Number, City
Hospital or Attending Physician: The law requires that the death certificate be executed by Attending Physician: The law requires that the death certificate death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highly that highest 2 events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond  25. Was case referred to medic examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Per Conditions of the condition of the co	a Head Injuring Due to (or as a beautiful beau	consequence of a consequence of a consequence of a consequence of a consequence of outcome of pregnish the nant at time of death own to death but not reconstruction of the consequence of Injury 2006 ce of Injury - At how of examination are	ER/Outpatient 28b. Time of Ir FOUND: 2012 hrs ome, farm, stree	al death 3 [ ner (Specify)  Inderlying cause g  26.Place 3 DOA  Injury 28c. Injury  1 1	of Death (Other 4 y at Work' es 2 villaling, etc	rt I.  (Check or ) Nursing ?  No	23e. Did  1 Ye  24a. Wa: auto perf  1 Yes  Ily one)  Home 5 S  8d. Describe ccupant of r Town, t. 40 & W  ue to the cat	tobacco u es 2  s an ppsy formed? 2 No Residen how injur of vehic (Street an State) /inters L use(s) and	Date of dimonth  No 3  24b. We pring de 1  Try occurred involved Number	elivery Day  ute to the cau Probably ere autopsy fi or to complet ath? Yes  Other: Scene d ved in colli	Year  Se of death?  Unknown Indings available on of cause of  No  Sion  te Number, City  MD
Hospital or Attending Physician: The law requires that the death certificate be executed the shours after death.  Function: After this certificate has been signed by the attending physician and the funeral Directors. After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highly that highest 2 events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond  25. Was case referred to medic examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Per Conditions of the condition of the co	b. Due to (or as a b. Due to (or as a d.  AMENDED  AMENDED  AMENDED  1 Live 4 Pregulation contributing to the contributing to the contribution contr	consequence of a consequence of a consequence of a consequence of a consequence of outcome of pregnish the nant at time of death own to death but not reconstruction of the consequence of Injury 2006 ce of Injury - At how of examination are	ER/Outpatient 28b. Time of Ir FOUND: 2012 hrs ome, farm, stree	al death 3 [ ner (Specify)  Inderlying cause g  26.Place 3 DOA  Injury 28c. Injury  1 1	of Death (Other 4 yat Work' Yes 2 viulding, etc.	rt I.  (Check or ) Nursing ?  No	23e. Did  1 Ye  24a. Wa: auto perf  1 Yes  Ily one)  Home 5 S  8d. Describe ccupant of r Town, t. 40 & W  ue to the cat	tobacco u es 2  popsy ormed? 2 No Residen how injur of vehic (Street an State) //inters L use(s) and e and place	Date of do Month  No 3  24b. We prive the prive the involved Number ane, Cate and due to the process of the prive the theorem and the prive the pr	elivery Day  ute to the cau Probably ere autopsy fi or to complet ath? Yes  Other: Scene d ved in colli	Year  se of death?  Unknown  Indings available  on of cause of  No  sion  te Number, City  MD
Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursass or in jury it at hithets 1 events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9  Ur  Part II. Other significant cond  25. Was case referred to medic examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Per Cardinal Suicide 6  Co det  29a. Certifier 1  Certifying 1 one) 2  Medical Ex	b. Due to (or as a b. Due to (or as a d.  AMENDED  AMENDED  AMENDED  1 Live 4 Pregulation contributing to the contributing to the contribution contr	consequence of a consequence of a consequence of a consequence of a consequence of outcome of pregnish the nant at time of death own to death but not reconstruction of the consequence of Injury 2006 ce of Injury - At how of examination are	ER/Outpatient 28b. Time of Ir FOUND: 2012 hrs ome, farm, stree	al death 3 [ ner (Specify)  Inderlying cause g  26.Place 3 DOA  Injury 28c. Injury 1 Ver, factory, office because in my opinion	of Death (Other 4 y at Work' es 2 villaling, etc	rt I.  (Check or ) Nursing ?  No	23e. Did  1 Ye  24a. Wa: auto perf  1 Yes  Ily one)  Home 5 S  8d. Describe ccupant of r Town, t. 40 & W  ue to the cat	tobacco u es 2  s an ppsy formed? 2 No Residen how injur of vehic (Street an State) /inters L use(s) and e and place	Date of do Month  No 3  24b. We prive the prive the involved Number ane, Cate and due to the process of the prive the theorem and the prive the pr	elivery Day  ute to the cau Probably ere autopsy fi or to complet ath? Yes  Other Scene d ved in colli or Rural Rou atonsville, as started. e to the cause d (Month, Da	Year  se of death?  Unknown  Indings available  on of cause of  No  sion  te Number, City  MD
Hospital or Attending Physician: The law requires that the death certificate be executed by Athoris after death.  Funeral Directors: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursass or in jury it at hithets 1 events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9  Ur  Part II. Other significant cond  25. Was case referred to medic examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Per Cardinal Suicide 6  Co det  29a. Certifier 1  Certifying 1 one) 2  Medical Ex	Due to (or as a b. Due to (or as a b. Due to (or as a c. Due to (or as	outcome of pregration and a consequence of pregration and at time of deal pown to death but not respect to the consequence of Injury 2006 and	ER/Outpatient 28b. Time of Ir FOUND: 2012 hrs ome, farm, stree d / Highway ge, death occur nd/or investigat	al death 3 [ ner (Specify)  Inderlying cause g  26.Place 3 DOA  Injury 28c. Injury  1 Y  It, factory, office b  red at the time, da ion, in my opinion  29c. Licens	of Death (Other 4 y at Work' es 2 villaling, etc	rt I.  (Check or ) Nursing ?  No	23e. Did  1 Ye  24a. Wa: auto perf  1 Yes  Ily one)  Home 5 S  8d. Describe ccupant of r Town, t. 40 & W  ue to the cat	tobacco u es 2  s an ppsy formed? 2 No Residen how injur of vehic (Street an State) /inters L use(s) and e and place	Date of dimension of the contribution of the c	elivery Day  ute to the cau Probably ere autopsy fi or to complet ath? Yes  Other Scene d ved in colli or Rural Rou atonsville, as started. e to the cause d (Month, Da	Year  se of death?  Unknown  Indings available  on of cause of  No  sion  te Number, City  MD
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed by the standard death.  Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or hijbry first hithors)  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Un  Part II. Other significant cond  25. Was case referred to medic examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Per (Check only one) 2 Medical Ex  29b. Signature and title of certifying it one) 2 Medical Ex  29b. Signature and dittle of certifying it one) 2 Medical Ex  30. Name and address of personance in the condition of the certifying it one)	Due to (or as a b. Due to (or as a b. Due to (or as a c. Due to (or as	outcome of pregration and a consequence of pregration and at time of deal arown to death but not reconstruction and a consequence of Injury - At how a consequence	ER/Outpatient 28b. Time of Ir FOUND: 2012 hrs ome, farm, stree d / Highway ge, death occur nd/or investigat	al death 3 [ ner (Specify)  Inderlying cause g  26.Place 3 DOA  Injury 28c. Injury  1 Y  It, factory, office b  red at the time, da ion, in my opinion  29c. Licens	of Death (Other, Value and planted death occurrence) of Death (Other, Value and planted death occurrence) of Death occurrence anumber M.E.	Check or Nursing No C R Ce, and d curred at 1	23e. Did 1 You 24a. Was auto perf 1 Yes  Ily one) 8d. Describe ccupant of 8f. Location or Town, t. 40 & W ue to the cat the time, date	tobacco u es 2  s an ppsy formed? 2 No Residen how injur of vehic (Street an State) /inters L use(s) and e and place	Date of dimension of the contribution of the c	elivery Day  ute to the cau Probably ere autopsy fi or to complet ath? Yes  Other Scene d ved in colli or Rural Rou atonsville, as started. e to the cause d (Month, Da	Year  se of death?  Unknown Indings available on of cause of  No  sion  te Number, City  MD

			1 - State of N	/laryland		tment of H <i>ificate of I</i>	lealth and M Death	lental Hygi Ra	ene g. No. 20 (	36	30018
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  RITA LERMA GOOSLIN	I				2. Date of Death Month		rear P(IXO	3. Time of Death 7:40 A M
	Examir		4a. Facility Name (If not institution, give street and number	ente	70	4b. City, Town, or	Location of Death	9,0	4c. County of	Death	5
	Funeral Director		5. Social Security Number 460-36-7144 6. Sex 1□ M XX F 7. /	Age (In yrs. Ias 78	st birthday) Yrs.	If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAY 22	Year)	- 17	ce (State or Foreign y) AS
	anyland ehow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca	ition				100	d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral Director	MARYLAND CHARLES  10e. Street and Number	WA	LDORF	10f. Zip Code		10	g. Citizen of Wh	nat Countr	1 ☐ Yes 2 ∑ No y?
ل	e 23e or	erai D	2740 MARLETTE PLACE  11. Marital Status 12. Was Deceder	et Even in U.S.	12.14	2060		and Was as No		S.A.	- In the
D38	within 72 hours atter dense of the manner. The mature!; or item	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deceder Armed Force 1 Yes, Sive Year or Dates	ş? JNo	lf \	Yes 2000	ispanic Origin? (Spin, Mexican, Puerto Specify:	Rican, etc.)	14. Race- Black, Specify:	White, et	te.
215-0	hin 72 h e. en "natu Medicel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  Coltege (1-4o		16a. Decede (Give ki life. Do	nt's Usual Occupa nd of work done of NOT use retired	ation during most of work ()	ing 1	6b. Kind of Busi	ness/Indu	stry
1 d 21:1	lied Lygin	e Com	12  17. Father's Name (First, Middle, Last)		HOMEM	AKER	18. Mother's Name		OWN HOL		
ylan	2 2 2 2 E	To Be	JOAQUIN LERMA					ELIZO			
Mar	and and se m		19a. Informant's Name/Relationship (Type, Print)				and Number or Run		-		
_ S,	s 1 and 2 f Health item 27 other tre		ROBERT L. GOOSLIN-SON 20a. Method of Disposition	20b. Plac		PPER P. ion (Name of tory or other place	INDELL F		Coc. Location - C		
, Ciri	Pages ment of ant; If it ury or o		Magarial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	10		ORIAL (	1	-15-06	WALDORI	F,MA	RYLAND
Balti	permit. Pages Depertment of Important: If i eny injury or once.		12/1/	100479	RA	YMOND I	FUNERAL	SERVIC	E, P.A		
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death.	Do not enter	the mode of dyin	g, such as cardiac	or respiratory arre	st,	, It	Approximate nterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	000	n Co	ancel					Diset and Dealis
	Examiner			Pulu	ince ot): WN pU	4 81	mbolisi	W.			
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a conseque		· Cin	mbolisie er Dire	14.6			
o o	icate be executed physician and s the burial-transit	Exan	triat irritiated events C.	as a conseque	nce of):	1 004	ec pire	<i>w</i> -			
68760,	ohysicia the bu	edical	d			Y					
Box 6	eath certific attending p for use as	√Me	tF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	ne of pregnanc					23d. Date	of delivery	,
.0. B	the d	Physician/M	in the nast 12 months?	2 ☐ Fetal d at time of dea		ctopic pregnancy Other (specify)			Month		ay Year
Division of Vital Records, P.O.	law requires that les been signed t s 2 should be det	र्व	Part It. Other significant conditions contributing to death	but not resulti	ing in the und	erlying cause give	en in Part I.		acco use contrib s 2 □ No 3		cause of death?
cor	aw requ s been 2 shoul	Completed						24a. Was an			y findings available
E Re	The lay cate hes page 2	Com						autopsy perform 1 Tes 2,	ed? dea	or to comp ath? Yes 2	
Vita	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpa			all DOA Othe	26. Place of Death				
o c	g Phy ler this neral di	n: To	27. Manner of Death 28a. Date of Ir		R/Outpatient	3 DOA 28c. Injury	4   Nursing no	me 5 Resider 28d. Describe hor			
sior	or Attending siter death. Director; Atter in by the fune	catlo	2 Accident investigation		Injury	M 1 🗆 '	Yes 2 □ No				
Divi	al or At efter of I Direct d in by	Certification:	determined 289. Place of I	Injury - At hom etc. <i>(Specify)</i>	ie, farm, stree	t, factory, office		28f. Location (Str. City or Town,	eet and Number State)	or Rural F	Route Number,
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the besis 2 Madical Examiner: On the basis manner	of examinatio	edge, death on and/or inve	ccurred at the tim stigation, in my op	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and mann te and place, and	er as stated due to the	ed. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie			29c. License	number	29	d. Date signed (	Month, Da	ay, Year)
	9		30. Name and address of per n who completed cause of	death (Item 2	23a) (Type, Pr	int)	and P	money /	3	160	र्गात मिन्न
	Sta	ite	31. Date filed (Month, Day, Year) 32. Regis	strar's Signatur	4	riwyi	MUTTU	Thurs !	WE W	JULI	MODE TO
	Registi	ar	SEP 2 1 2006	wind do	Ap.	MES					

nysician	Decedent's Name (First, Middle, Las		Certificate of Death	2. Date of Death Month	Day Year
Medical	Randolph B. G				31 200/ 1249
xaminer	4a. Fecility Neme (If not institution, give	street and number)  Medicol (SENTER)	4b. City, Town, or Location of Dec	4	4c. County of Death
eral ctor	5. Social Security Number 6. Se 220–26–8817	7. Age (In yrs. last In present the presen	birthday) If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birthplace (State or For Country)  927 Maryland
H .	Usuel Residence of Decedent  10a. State 10b. County		own or Location		10d. Inside City L 1 ∐ Yes 2
by Funeral Director	MD Wicomi  10e. Street and Number	.co Sali	Lsbury  10f. Zip Code	100	g. Citizen of What Country?
alD	109 Francis Drive		21804		U.S.A.
<u>م</u>	11. Marital Status  1 □ Never Married 2 □ Married  3 ② Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1. 125Yes 2 □ No If Yes, Give Year or Dates: 1947	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 ■ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
Completed	15. Decedent's Ed (Specify only highest grad	lucation de completed)	Ga. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	rorking 16	6b. Kind of Business/Industry
E	Elementary/Secondary (0-12)	College (1-4or 5+)	Engineer		Healthcare
Bec	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Ma	aiden Surname)
<b>To E</b>	Lawrence Godfrey		Kate	Beauchamp	
r.s	19a. Informant's Name/Relationship (7	1	9b. Mailing Address (Street and Number or i		
			4245 Slater Avenue		ore, MD 21236
	20a. Method of Disposition  1 Surial 2 Cremation 3	rama	of Disposition (Name of tery, crematory or other place)	05-2006	0c. Location - City or Town, State
	4 Donation 5 Other (Specify	. OP L LIN	ghill Memory Gardens	Н.	ebron, Maryland
	21. Signature of Funeral Service Licen:	see	22. Name and Address of Facility  Short Funeral Hor	m <u>e</u>	
_	T. gavae		13 E. Grove St.	Delmar, D	
	shock, or heart failure. List only of	one cause on each line.	o not enter the mode of dying, such as card	ac or respiratory arres	Interval Betwee
1	Immediate Cause (Final disease or condition	· MESENTER	a colomidad and	0	411
		a	c artery hemore	age	240
	resulting in death)	Due to (or as a consequence		age	2400
		b	e of):	age	240,
liner			e of):	age	240,
xaminer		b. Due to (or as a consequence.	e of):	age	240,
al Examiner		b	e of):	age_	240,
cal		b. Due to (or as a consequence.	e of):	age	240,
cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last	b.  Due to (or as a consequence d.	e of):	age_	240
cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.	the of):  se of):  se of):  the 3 □Ectopic pregnancy	age	23d. Date of delivery  Month Day Year
cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	b.  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	the of):  a of):  a of):  the of):  the of):  Other (specify)	23e. Did toba	1
cal	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	b.  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	the of):  a of):  a of):  the of):  the of):  Other (specify)		M <i>on</i> th Day Year
cal	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	b.  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	the of):  a of):  a of):  the of):  the of):  Other (specify)	1 ☐ Yes	Month Day Year  accoluse contribute to the cause of deat  2 ☑ 1√0 3 ☐ Probably 4 ☐ Unkr
cal	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	b.  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	the of):  a of):  a of):  the of):  the of):  Other (specify)		Month Day Year  Coo use contribute to the cause of deatl  2 2 No 3 Probably 4 Unkn  24b. Were autopsy findings ava prior to completion of caus death?
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions or periton; the past 12 months?  Periton; TS  Previous	b.  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal dea 4   Pregnant at time of death 9   Unknown	the of):  the of):  the 3 □ Ectopic pregnancy 5 □ Other (specify)  g in the underlying cause given in Part I.	24a. Was an autopsy performe	Month Day Year  accoluse contribute to the cause of deatl  2 No 3 Probably 4 Unkn  24b. Were autopsy findings ava prior to completion of caused death?  1 Pres 2 No
Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions of the present of the prese	b.  Due to (or as a consequence of pregnancy 1	th 3 Ectopic pregnancy 5 Other (specify)  g in the underlying cause given in Part I.	1 Yes  24a. Was an autopsy perform 1 Yes 2 [ eath (Check only one)	Month Day Year  acco use contribute to the cause of deatl  2 No 3 Probably 4 Unkr  24b. Were autopsy findings ava prior to completion of caused? No 1 Probably 2 No
To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the present choice and the present	b.  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown  ontributing to death but not resulting	th 3 Ectopic pregnancy 5 Other (specify)  g in the underlying cause given in Part I.  26. Place of D  Outpatient 3 DOA Other: 4 Nursing	24a. Was an autopsy performs 1 2 Yes 2 [eath (Check only one)]	Month Day Year  acco use contribute to the cause of death  2 No 3 Probably 4 Unkn  24b. Were autopsy findings ava prior to completion of cause death?  No 1 Pes 2 No  No 6 Other (Specify)
To Be Completed by Physician/Medical	Sequentially list conditions, if any, reacting to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions or perior to the past of the cause of the caus	b.  Due to (or as a consequence of Due to (or as a consequence	the of):  a of	1 Yes  24a. Was an autopsy perform 1 Yes 2 [ eath (Check only one)	Month Day Year  acco use contribute to the cause of death  2 No 3 Probably 4 Unkn  24b. Were autopsy findings ava prior to completion of cause death?  No 1 Pes 2 No  No 6 Other (Specify)
To Be Completed by Physician/Medical	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b.  Due to (or as a consequence of pregnancy of the consequence of pregnancy of the consequence of pregnancy of the consequence	the of):  about a line of line	1 ☐ Yes  24a. Was an autopsy perform 1 ☐ Yes  24a. Was an 24b. Yes 2 ☐ 25b. The state of the st	Month Day Year  Acco use contribute to the cause of death  2 No 3 Probably 4 Unkn  24b. Were autopsy findings ava prior to completion of cause death?  No 1 Pes 2 No  No 1 Probably 4 Unkn  Completion of cause death?  Indice 6 Other (Specify)  In injury occurred
Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of Due to (or as a consequence	the of):  about a line of line	24a. Was an autopsy performs.  24a. Was an autopsy performs.  24beath (Check only one)  Home 5 Residen  28d. Describe how  28f. Location (Stree City or Town,	Month Day Year  Acco use contribute to the cause of death  2 No 3 Probably 4 Unkr  24b. Were autopsy findings avaration to completion of caused?  1 Pres 2 No  2 No  2 Other (Specify)  2 Injury occurred  2 and Number or Rural Route Number, State)
To Be Completed by Physician/Medical	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions or period of the examiner? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    27. Manner of Death   Immediate   Investigation   Investi	b. Due to (or as a consequence). c. Due to (or as a consequence). d. 23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal dea 4   Pregnant at time of death 9   Unknown ontributing to death but not resulting to death but not resulting 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, building, etc. (Specify)	th 3 Ectopic pregnancy  5 Other (specify)  g in the underlying cause given in Part I.  26. Place of D  Outpatient 3 DOA Other: 4 Nursing  7. Time of Injury M 1 Yes 2 No  farm, street, factory, office	24a. Was an autopsy performs 1 Yes 2[ Peath (Check only one) 1 Home 5 Residen 28d. Describe how 28f. Location (Stree City or Town, ce, and due to the caucurred at the time, date	Month Day Year  Acco use contribute to the cause of death  2 No 3 Probably 4 Unkr  24b. Were autopsy findings avaration to completion of caused?  1 Pres 2 No  2 No  2 Other (Specify)  2 Injury occurred  2 and Number or Rural Route Number, State)
Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions or period of the present of the presen	b. Due to (or as a consequence of Due to (or as a consequence	the of):  a of	24a. Was an autopsy performs 1 Yes 2  Peath (Check only one) Home 5 Residen 28d. Describe how  28f. Location (Stree City or Town,  ce, and due to the caucurred at the time, date	Month Day Year  Acco use contribute to the cause of death  2 No 3 Probably 4 Unkn  24b. Were autopsy findings ava prior to completion of caus death?  No 1 Pes 2 No  No 6 Other (Specify)  Vinjury occurred  Deet and Number or Rural Route Number.  State)  Use(s) and manner as stated.  Lee and place, and due to the cause(s)  d. Date signed (Month, Day, Year)
Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions or period of the examiner? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    27. Manner of Death   Immediate   Investigation   Investi	b. Due to (or as a consequence of Due to (or as a consequence	th 3 Ectopic pregnancy 5 Other (specify)  g in the underlying cause given in Part I.  26. Place of D  Outpatient 3 DOA Other: 4 Nursing 0. Time of Injury M  farm, street, factory, office  1ge, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation, in my opinion, death occurred at the time, date and pla and/or investigation.	24a. Was an autopsy performs 1 Yes 2  Peath (Check only one) Home 5 Residen 28d. Describe how  28f. Location (Stree City or Town,  ce, and due to the caucurred at the time, date	Month Day Year  Acco use contribute to the cause of death  2 No 3 Probably 4 Unker  24b. Were autopsy findings ava prior to completion of caused death?  No 1 Pes 2 No  No 6 Other (Specify)  Vinjury occurred  Deet and Number or Rural Route Number.  State)  Use(s) and manner as stated.  Lee and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5

		For State Registrar	State of Maryland	Depa <i>Cer</i>	urtment of Ho <i>tificate of L</i>	ealth and N Death		gieneZ	006	300	121
Physicia	an	1. Decedent's Name (First, Middle, Last)		_			2. Date of Dea Month	ith Day	Year	3. Time of (	
/Medic			Heron				Sept.	_	2006	7:18	РМ
Examin	er	4a. Facility Name (If not institution, give s Glade Valley Nur			4b. City, Town, or Walkers				inty of Death derick		
Funeral Director		212-05-2338	7. Age (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Sept. 1	r, Year)	9. Birth Cou 6 Mar	place (State or ntry) yland	Foreig
f show	10.	Usuel Residence of Decedent  10a. State  10b. County  Maryland Frederick		Town or Lo						10d. Inside City	•
28a-	rect	10e. Street and Number	56	DIII	10f. Zip Code			10g. Citizen	of What Cou	ntry?	
3a or	ā	17601-F Sunshine	Trail		21780			Unite	d Stat	es	
be filled within 7 c nouts after death with the maryland that Hygiene.  vid other then "natural", or items 23a or 28a-f show event, the Middleal Examiner must be notified at	by Funeral Director		I2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		Race - Ameri Black, White ecify: White	etc.	
ninin 72 no 19. hen "natura Medical E	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of work	king		f Business/Ir	·	
e med within al Hygiene. I other then '	S	8		Ho	memaker	18. Mother's Nam	a /First Middle		Own Ho	me	
and Mental File marked off	To Be	17. Father's Name (First, Middle, Last) William Hickmen				Netti	e H. Liv	ingst	one		
th and h		19a. Informant's Name/Relationship (Type Wesley Dotson / Gr			g Address (Street a -F Sunshi						780
ages ran		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	ace of Dispo metery, cren	sition (Name of natory or other place	Sept	Date ember	20c. Location	on - City or T	own, State	
permit rages I and a should be perment of Health and and in the perment of Health and permet important: If Item 27 is and marked eny injury or other treumatic society.		4 Donation 5 Other (Specify)  21. Sign rure of F		22	n Mem. Gar Name and Addres 21 Opossu	s of Facility St	auffer E	Tunera	1 Home		
The elevation certificate by executed by the elevating physicien and the elevating physicien and the elevation and the e	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	ence of): ence of):	hea.	77 / 6	vure			3 my	5.
ed by the ettending pt detached for use es t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d.	Date of deliv Month		ear
igned b	Ď	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did to			the cause of de	
ate has b	Completed								b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings a empletion of ca 2 No	vaila use
r this certificat ral director, pa	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	1	ER/Outpatien		Nursing H	th (Check only or one 5 Resid	lence 6 🗆		fy)	
leath. tor: Afte the fune	Certification;	1 Natural 5 ☐ Pending  '2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)  28e. Place of Injury - At hor	Injury	M 1□1	?` ∕es 2□No	28f. Location (S			al Route Numb	
within 24 hours after of To the Funerel Direct completely filled in by		4 Homicide determined  29a. Certifier Certifying Phys	building, etc. (Specify, sician: To the best of my know			e date and place	City or Tow	m, State)			
within 24 hours To the Funerel I completely filled	dedical	(Check only 2 Medical Examir	ner: On the basis of examinati and manner stated.	ion and/or in	estigation, in my op	oinion, death occur	red at the time, o	date and pla	ce, and due t	o the cause(s)	
	Σ	29b. Signature and title of certifier			29c. License				gned (Month.	Day, Year)	
To To		Maria 1	firm N Sho		Print) Freder	642		9.11	or		

				epartment of Health and Certificate of Death		iene g. No. 2006 30021
	0		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year
	Physicia /Medic		Dorothy Amelia Hager		09	03 2006 12:00 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	eath	4c. County of Death
			Calvert Manor Healthcare Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birth.	Rising Sun	Irs. 8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		176–18–6523 1□M 2XF 84 Yr	Months Days Hours Mi	in. (Month, Day, 05/05/	Year) Country)
	D		Usual Residence of Decedent			
	arylar show	5	10a. State   10b. County   10c. City, Town of DE   New Castle   New Cas			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	ecto	10e. Street and Number	10f. Zip Code	11	Og. Citizen of What Country?
	with Sa or	Funeral Director	19 Cherry Road	19720		USA
	death ms 2:	era	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,
စ္	after or Ita	/ Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No	If Yes, specify Cuban, Mexican, Put  1 Yes 2 No Specify:	eno rican, etc./	Black, White, etc.  Specify: White
8	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f show the Medical Exemples must be notified at	d by	3 X Widowed 4 □ Divorced Year or Dates:		F :	
7	in 72	olete	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of w fe. DO NOT use retired)	working	16b. Kind of Business/Industry
212	l with jiene. r thar	Completed		ales Clerk		Government
bu	e filed al Hyg l' othe vent,	Be C	17. Father's Name (First, Middle, Last)		Name (First, Middle, M	faiden Sumame)
ylaı	Ments Ments arked	To	Raymond A. Flowers		Woodward	
Maryland 21215-0036	12 short and risem			Mailing Address (Street and Number or		
e,	is 1 and 2 of Health a item 27 is other trai		20a Method of Disposition 20b. Place of D	Cherry Road, New Disposition (Name of		20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Itams 23a or 28e-1 show appriently or other traumatic event, the Medical Examinat must be notified at once.			crematory or other place) ro Cemetery 9/	7/2006	Hatboro, PA
alti	mit. F partme sorter / injur		21. Signature of Euneral Service Licensee	22. Name and Address of Facility F	Pamily Fund	oral Homo
m	permi Depar Impo any ir		Estwart Mc from	635 Churchmans Rd	Newark, I	DE 19702
	Physician physician and physician and physician and physician and the phriat-transit	Examiner	23a. Part 1. Enter the disease, of complications that caused the death. Do no shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of Due to (or	Dostructive P		Interval Batween Onset and Death Weeld
.O. Box 68760,	the death certific y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P	se of ed	by	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
Vital Records,	The law ate has b page 2 s	Completed	Diabetos, TypeTT		24a. Was al autops perform 1 \( \text{Yes} \) 2	y prior to completion of cause of
Vita	Physician: The this certificate al director, pages	Be	25. Was case referred to medical examiner?	Othor A	Death (Check only on	
of		: To	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at		nce 6 □Other (Specify) w injury occurred
ion	Attending Ph ir death. ector; After th by the funeral	atlor	1 Natural 5 □ Pending (Month, Day Year) Inj 2 □ Accident investigation	ury Work?  M 1 □ Yes 2 □ No		
Division	I or Attendi after death. Director: A I in by the fu	Certlflcation:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fam building, etc. (Specify)	ı, street, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
	urs after rel Dir lled in					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) (Check one) (Check only o			
	To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number	2:	9d. Date signed (Month, Day, Year)
)	->=0		noi08 from mis	DODSRECT	-u	9/2/06
			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)		
	5		101 COLONAL Way, Suite A	Kising Sun,	MD 2	1911
•	Sta Registi		31. Date filed (Month, SE Par) 8 2005 32. Registrar's Signature	Rising Sun.		

		• • • • • • • • • • • • • • • • • • • •	nd / Department of Health and	•	
	1 - For State Registrar	State of Marytar	Certificate of Death		2006 30022
4.0	Registrar  1. Decedent's Name (First	, Middle, Last)	Certificate of Death	2. Date of Death	3. Time of Death
Physician		Ann	Hartmaier		Day Year
/Medica Examine	4- English bloom /// makin	stitution, give street and number)	4b. City, Town, or Location of Dea		Ac. County of Death
Examine	O 11 1	Rehab & Mursin	actr. Salisbur		Wicomico
Funeral	5. Social Security Number	6. Sex 7. Age (In yrs.	Mist birthday) If Under 1 Year If Under 24 Hr	8. Date of Birth	9. Birtholace (State or Foreign
Director	215-20-2167	1□M 2\ F 80	Yrs. Working Bays Trodis	06-10-192	
and *	Usual Residence of Deced 10a, State 10b.		ty, Town or Location		10d. Inside City Limits
Aarylis r sho					1 ☐ Yes 2X No
ith the Marylar or 28a-f show	MD Wi	comico Sal	isbury 10f. Zip Code	10g. (	Citizen of What Country?
With With	2207 Allen	Drive	21801		SA
1215-0036  "It is a Madical Examinar must be notified at the Maryland and Maryland and Maryland and Maryland and Madical Examinar must be notified at the Madical Examinar must be notified at the Madical Examinar must be notified at the Examinar must be not the Exam	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Specify Yes or No-	14. Race - American Indian,
atter or its	1 ☐ Never Married 2	☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:	no nican, etc.)	Black, White, etc.  Specify: White
15-0036	3 X Widowed 4 □ D	ivorced Year or Dates:			
+ 127 17 17 17 17 17 17 17 17 17 17 17 17 17	15. D (Specify only Elementary/Secondary 12	ecedent's Education y highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of will life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
Within within	Elementary/Secondary	(0-12) College (1-4or 5+)	Seamstress		irt Factory
d d d d d d d d d d d d d d d d d d d	17. Father's Name (First,	Widdle, Last)		ume (First, Middle, Maid	
ld be entai	Robert J.Ell	iott	Gertr	ude Hollowa	У
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at The Polymeric American Plants of the Control of the Co	19a. Informant's Name/Re	alationship (Type, Print)	19b. Mailing Address (Street and Number or F	Tural Route Number, City	y or Town, State, Zip Code)
mand 2	Frances Mum	ford - sister	13040 Riggin Ridge Ro	ad, Ocean C	Sity, MD 21842
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than any injury or other traumatic avent, train gonce.	20a. Method of Disposition	notice 2 DRomovel from State	Place of Disposition (Name of cemetery, crematory or other place)	OF 2006	Location - City or Town, State
Pag ment ant: i	4 Donation 5 0	Other (Specify)	ringhill Memory Gard	He	bron, Maryland
Baltim Permit. Pa Departmen Important: sny injury	21. Signature of Funeral S	Service Licensee		Bounds Fune:	
ш 40.5 4 4	In	~ > felly	705 E. Main Stree		
	shock, or heart failu	re. List only one cause on each line.	th. Do not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	-a likeun	ord or the	140	year-
Examiner		Due to (or see consec	quince or):		wonn-
MARKET ST	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	Due to (or as a consecute	quence of):		1 2 7
cuted	that initiated events				·
		Due to (or as a consec	quence of):		
0 00 0		d			
OX 68  n certificate anding physics as the	IF FEMALE:	22a. If was autooms of progs	2004		
Box 6 eath certif	23b. Was decedent pregr in the past 12 month		al death 3 □Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O. that the de by the detached	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	death 5 Gitter (specify)		
IS, P.(	Part II. Other significant	conditions contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tobaco	o use contribute to the cause of death?
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifical cleath. sctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 Yes 2 No 9 Unknown  Part II. Other significant of			1 Tes	2 No 3 Probably 4 Unknown
aw requir	<u> </u>			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Reconstruction of the law te has age 2				autopsy performed?	death?
Vital F ician: Th certificate fector, pag	25. Was case referred to	medical	26, Place of De	eath   Check only one	40 .0163 20140
Of V Physic	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA Other: 4 4 Hursing	Home 5 ☐ Residence	6 ☐Other (Specify)
Vision of Vital Reatenating Physician: The st death.  Sector: After this certificate his by the funeral director, page		Pending 28a. Date of Injury (Month, Day Year)	28b. Time of lnjury at Work?	28d. Describe how in	jury occurred
Sio tendi eath. tor: A	2 Accident 3 Suicide 6	investigation	M 1 Tyes 2 No		
Division of Vital Records, P.O. Box 68 to Attanding Physician: The law requires that the death certificat after death.  Diractor: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the setting of the control of the setting of the se	27. Manner of Death  1 @Natural 5 C  2 Accident  3 Suicide 6 C  4 Homicide	determined 28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factory, office fy)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Hospital or Hospital or 14 hours afte Funeral Diri		Stituing Physician: To the heet of my kn	owledge, death occurred at the time, date and place	ea and due to the cause	(c) and manner as stated
Hos 24 h	29a. Certifier 1 2 6 (Check only one)	ledical Examiner: On the basis of examina and manner stated.	ation and/or investigation, in my opinion, death occ	curred at the time, date a	and place, and due to the cause(s)
Division  To the Hospital or Attanding Fwithin 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	29b. Signature and title of	centrier	29c. License number	C) 29d. (	Date signed (Month, Day, Year)
00	100	Mars	07534	1 8	28/16
- 12 PM		person who completed cause of death (Itel	m 23a) (Type, Print)	01.	1
( ) °	William	H. Robins, M.	D. 200 Civic Au	e, Solish	Juny, MD 21804
State Registra	0.110		H. Ann A a		

DHMH 17 Rev 1/2001

ORIGINAL

Uladys HARMON 217-28-4856

			Chata of Mandard / Denotrant		_		
			State of Maryland / Department State of Maryland / Department Certificate			2000	30023
			Tiogram		Reg. N	· Z U U O	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last)		Month D	ay Year	0840 M
	/Medic	al -	GLADYS ELIZABETH HARMON		SEPT. 1	2006	0570
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, To	own, or Location of Death	4	c. County of Death	
			F. Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1	Year If Under 24 Hrs. 8	Date of Birth	WICOMI	
	Funeral	- 1	Months Months	Days Hours Min.	. Date of Birth (Month, Day, Yea		lace (State or Foreign
	Director		217-23-4856 The Price of Decedent To The Price of Decedent		12-20-	30	עוון
	land		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Mary	Ď	MD SOMERSET PRINCESS	ANNE			1 Yes 2 □ No
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28e-f ehow the Madical Examinar must ke notified at	Director	10e. Street and Number 10f. Zip C	Code	10g. C	itizen of What Cour	try?
	3s or	ੂ	30569 CREEKVIEW DRIVE 2	1853		1) 5+	3
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent	int of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	fy Yes or No-	14. Race - Americ Black, White,	
٥	after or Ite		Armed Forces? If Yes, specific Tolerand In Never Married 2 Married 1 Section 1 Yes, Specific Tolerand It Yes, Give 1 Yes, Specific Tolerand It Yes, Give 1 Yes, Specific Tolerand It Yes, Specific Toler		Carr, etc.,		etc.
3	ours a	þ	3 Widowed 4 □ Divorced Year or Dates:	a no specify.		Specify: B	ACK
2-003p	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	done during most of working		Kind of Business/In-	dustry
V	thin le	ā	Elementary/Secondary (0-12) College (1-4or 5+)		11		1).
N	filed w Hygier Ither th	S	LABOR		HO.	LY FARMS	MATCHERY
ב	e a a b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	rirst, Middle, Maide	an sumame)	CTOR
Maryland	should nd Men marke umatic	၉	GEDRGE ERNEST BRATTEN	MAE	ERTRUD	E DRAT	ren.
ā	C/ cg == =			Street and Number or Rural	Houte Number, City	or rown, State, Zip	Code)
	and lealth m 27 her tu		TONY HARMON ~ SON 25040 W 20a. Method of Disposition (Name	BURY CODA	T - 377 CL	Location III or To	Wn State
0	Pages 1 nent of H int: If ite iry or ot		1 ■ Burial 2 □ Cremation 3 □ Removal from State	ner place)		200411011	MAA
altimore,	. 5 5 2		F Donation 5 Other (Specify)	CEM. 419	106 121	RDLETKE	TIP
Ba	permit. Departr Imports any inj once.		21. Signature o Funeral Service Licensee	Address of Facility B		MITH	7/#
	707 # Q		Marie Mayer 717-4)	LSABELLA S	T, SAL	isbury, r	Approximate
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying, such as cardiac of	respiratory arrest,	/	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)				
	/Medical Examiner		Due to (or as a consequence of):				
п		er	Sequentially list conditions, if any, landing to immediate Due to (or as a consequence of):				
	ed Isit	lne	cause. Enter Underlying Cause (Disease or injury				
	xecut end il-trar	Examin	that initiated events c. Due to (or as a consequence of):				
9	or Attending Physician: The law requires that the death certificate be executed titler death. Director: Atter this certificete hes been signed by the attending physician end Director: Atter this certificate hes been signed by the attending physician end in by the tuneral director, page 2 should be detached for use as the burial-transit	calE					
687	icate phys		0.				
×	certif ding se a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
ĕ	atter atter	clar	in the past 12 months?  1 Yes 2 No			Month	Day Year
P.O. Box	that the de ned by the a detached f	lsk	9 ☐ Unknown				
<u>.</u>	that ned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	use given in Part I.	23e. Did tobacc	o use contribute to t	ne cause of death?
g	w requires that been signed I should be det	å d	Amal failure		1 🗆 Yes	2 No 3 Prot	ably 4 🗹 Unknown
8	s bee	et			24a. Was an	24b. Were auto	psy findings available
æ	he lav e hes age 2 :	Completed	V		autopsy performed 1 Yes 2	death?	mpletion of cause of
Division of Vital Records,	iician: Th certificete rector, pag	a)	25. Was case referred to medical	26. Place of Death	<u> </u>	10 100	22.10
>	ysici, s cer direct	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DO	A Other: 4 Nursing Hom	e 5 Residence	6 ☐Other (Special	(y)
<u></u>	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	3c. Injury at 25 Work?	8d. Describe how in	jury occurred	
<u>o</u>	nding f ath. r: After e funer	atlo	1 Natural 5 Pending (Month, Day real) Injury 2 Accident investigation M	1 ☐ Yes 2 ☐ No			
<u>S</u>	Atte	if	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 2	Bf. Location (Street City or Town, St.	and Number or Rura	al Route Number,
Ö	s afte	Certification;					
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation,	in my opinion, death occurre	nd due to the mause d at the time, date a	(s) and mannar as s	
	the H iin 24 the F iplete	ledical	one) and manner stated.	13		Data aig (****	
	With To	Σ	29b. Signature and title of certifier	License number	29d. l	Date signed (Month,	Day, redij
•			1 ( ) 20	N 001 170	0	11106	)
			30. Name and address of person who complete case of death (Item 23a) (Type, Print)	1. 1.		in fl	
			(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.  29b. Signature and title of certifier  29c.  30. Name and address of person who complete is able of death (Item 23a) (Type, Print)  SIMONA ENGLO DO 100E CAMMUL St.	HIIS BUNY M	1d 218	04	
14	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 6 2006 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 U U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** EDITH A. HARRISON Sept 2006 10:43 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare - The Pines Talbot Easton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
AUG 30, 1918 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 🕇 F MARYLAND 88 Director 213-05-6961 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be inclined at Yes 2 No Director TALBOT EASTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMANS LANE 21601 TISA Funerai Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, Ing. Na. 2008. Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGIA FRAMPTON ADDISON L. ANDREW 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIA H. BELL/DAUGHTER 106 MEADOW DR., APT.312, EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 9/9/2006 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facilii FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA oseph M. Ostwall. 200 S. HARRISON ST EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a rato unovella Physician Mars /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2□ No 2 2 No 1 Yes 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 3 No Other: Surring Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pendina i hours after death. uneral Diractor: Aft sly filled in by the fur 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 32. Regis 31. Date filed (Month, Day, Year) 's Signature State Registrar

Charles David Hurst

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

6

		I- For State Certificate of E	Death	Reg	No. 200	6 3002		
Physicia Medical Exami	in/	1. Decedent's Name (First, Middle, Last) CHARLES DAVID HURST	2. Date of Death Month September	Day Year 7, 2006  4c. County of Death	3 Time of Death 1010 hrs			
Funeral Director	- 1	236-02-7802 XXM 2 F 40 Yrs	Months Days Hours Min					
any		Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location	i			10d Inside City Limits		
vland -f show once	ğ	MARYLAND CHARLES NEWBU	JRG 10f. Zip Code	I 10e	Citizen of What Cour	1 Yes 2 X X O		
th the Maryland 23a or 28a-f show any notified at once,	<u>e</u>	10e Street and Number 19831 SYLVAN TURN	20664	100	U.S.A			
hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner myst be notified at once	_	11. Marital Status 1 X XNever Married 2 Married 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X X No 13. Was If Yes,	Decedent of Hispanic Origin? ( , specify Cuban, Mexican, Pue es 2XXNo specify:		14 Race - Ameri White, etc.	can Indian, Black,		
urs afte tural",	<u>ā</u>	or Dates.  15 Decedent's Education (Specify only highest grade completed)  16a. Decedent's	Usual Occupation (Give kind		Specify: 16b Kind of Business/I	WHITE ndustry		
21 3	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	t of working life. DO NOT use i $ABLED$	retired)	NONE			
5-0036 led within Hygiene other that	Com	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma	NONE			
21215-0036 uld be filed within 7 Mental Hygiene marked other that	ш,	WILLIAM HAROLD HURST  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing A	MARY  Address (Street and Number	ELIZABI				
MD 2 d 2 shou lth and N n 27 is r aumatic	<b>⊢</b>	MARY E. PADGETT-MOTHER 9831 S	SYLVAN TURN,	NEWBURG	MD 20664			
		20a. Method of Disposition  20b. Place of Disposition  20c Place of Disposition crematory or other  4 Donation 5 Other Specify: TRINITY MEMO	PRIAL GDNS	9-12-06	20c. Location - City or			
Baltimot permit. Page Department Important: injury or of		21 Signature of Funeral Service Licensee M00479 22. Nan R.A.	ne and Address of Facility AYMOND FUNER	RAL SERVI	CE, P.A.			
Physician /Medical		23a. Part I Enter the disease, or complications that caused the death Donot enter the failure. List only one cause on each like	mode of dying, such as cardia	CYLAND 2( ac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and		
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hyrertensive cardiovascular Due to (or as a consequence of):	disease			Death		
Polyman in the	-	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Control of the						
evecuted an and al - transit		d						
0, e be ysici buri	/Medical	X UNPENDED #23a,PII,27,perME,g8	360, 10/26/06 TT		23d Date of delivery			
	Physician/N	23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal	death 3 Ectopic pre-	gnancy		Day Year		
ires that the c signed by the	ğ	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		acco use contribute to 2 No 3 Prot			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed			24a Was ar autopsy perform 1 Yes 2	prior to oned? prior to o	topsy findings available completion of cause of		
tal Rectian: The	Be	25 Was case referred to medical examiner? Hospital: 4 Inspirate 2 FR(Outsets of the control of t	26 Place of Death (Che					
of Vi r Physi ter this eral dii	٠. ح	1 ✓ Yes 2 No Impatient 2 Exodupation 27 Manner of Death 28a Date of Injury 28b. Time of Injury	5 BOA 7 NO		esidence 6 🗸 Other	Scene		
ion c tending eath tor: Af the fun	ation	1 X Natural 5 Pending 2 Accident Investigation (Month, Day Year)	1 Yes 2 No					
Division spital or Attent hours after death meral Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, (Specify)	factory, office building, etc	28f Location (Sti or Town, Sta		ral Route Number, City		
To the Hospital within 24 hours To the Finneral completely fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated						
F % F 8	Me	29b Signature and life of certifier  Aphroca Sasell, UD.	29c. License number O.C.M.E.		29d Date signed (Moi September 8, 20			
K		30 Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Pe	nn Street, Baltimore, N	1D 21201				
S Regis	tate trar	31 Date filed (Month, Day, Year) 32. registrar's Signature SEP 2 1 2006	P. P					

DHMH 17 Rev 1/2001

Registrar 2006

**ORIGINAL** 

	For State Of Ividity and C	/ Department of Health and M Certificate of Death	Reg. No. 2006 30028					
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Adolf Hofman  4a. Facility Name (If not institution, give street and number)  Pannswa Regiowal Medical Curr	4b. City, Town, or Location of Dealh  SAUSBUR A	2. Date of Death Month Day Year August 4c. County of Death  W.C.M.C.					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 213–38–1929 13. M 2 F 83		8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New Jersey					
fied at		own or Location	10d. Inside City Limits 1 A Yes 2 □ No					
It be not	10e. Street and Number 711 Main St.	10f. Zip Code 21861	10g. Citizen of What Country? USA					
dical Examiner must be notified at etect by Funeral Director	11. Marital Status  1. Marital Status  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Mas Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 █ No Specify:	acify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White					
M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12	Decedent's Usual Occupation     (Give kind of work done during most of workilife. DO NOT use retired)  Inspector	ng 16b. Kind of Business/Industry  Sheet Metal					
To Be C	17. Father's Name (First, Middle, Last) Adolf Hofman	18. Mother's Name	o (First, Middle, Maiden Sumame) ce Henery					
To Be Comp	19a. Informant's Name/Relationship (Type, Print) Florence Erickson/Friend	19b. Mailing Address (Street and Number or Rura 711 Main St., Sharpt						
		e of Disposition (Name of stery, crematory or other place)  sbury Crematory 8/31	20c. Location · City or Town, Stale 20c. Salisbury, MD					
eny injury o	21. Sign was of Funeral Service Vicensee	2 Holloway Funeral H 501 Snow Hill Rd.,	Nome Professional Association Salisbury, MD 21804					
sthe burial-transit	d							
be detached for use as in by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnanc: 1 □ Live birth 2 □ Festal de 4 □ Pregnant at time ol deal 9 □ Unknown	eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown					
Somp	25. Was case relerred to medical		24a. Was an autopsy performed 2.  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No					
funeral direction: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EF	VOutpatient 3 DOA Other: 4 Nursing Ho	n (Check only one)  me 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred					
led in by the funera Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - Al home building, etc. (Specify)	e, farm, street, factory, office	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>					
pletely fill	one) and manner stated.	n and/or investigation, in my opinion, death occurr	ed at the lime, date and place, and due to the cause(s)					
E 000	29b. Signature and title of certifier	29c. License number	290 Date signed (Month, Day, Year)					
no	30. Name and address of person who completed cause of death (Item 2: William Robins Genesis Elder Care	Salisbury nd 21801	<i>(</i>					

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 30029 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Elset Morcos Ishak 6:45P<sup>M</sup> September 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Nursing & Rehab Center <u>Rockville</u> Montgomery If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 17 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) 1914 1 □ M 200 F 91 Egypt Director 223-43-6356 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show any injury or other trearmatic event, its Medical Exama per must be notified at once. 1 ☐ Yes 2 No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20604 Hartsbourne Way 20874 Egypt Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify. Specify 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Galila Henien Morcos Ishak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20604 Hartsbourne Way Germantown, Md. 20874 ace of Disposition (Name of Date 20c. Location - City or Town, S Nashed Samaan/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sep. 6, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Md. Gate of Heaven Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signat P Funeral Money & King Funeral Home, Inc. 171 W. Maple Ave., Vienna, Va. 22180 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 1 Wk PROBABLE ATHEROSCLEROTIC HEART DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, tany leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Yes 2 No 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hypertension; Renal Failure 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Stroke this certificate has 2□ No 1 ☐ Yes 2K No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA 28a. Date ol Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.Funerel Director: After the Certification: Injury 5 Pending 2 No 1 Yes 2 Accident investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital c within 24 hours af To the Funerel D 1 ី Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifie (Check ont P Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D28656 September 05,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 Ravi Passi, MD 8609 Second Ave., #404B, Silver Spring, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 30030 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 3 2006 **Physician** 4:50 A. M September Donald Robert Jeffery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Casey House Montgomery Rockville If Under 1 Year II Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 30, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) .Yea()927 **Funeral** 79 121M 2□ F 397-22-7075 Michigan Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Deportment of Heatth and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Iteme 23a or 28a-f ehow importent: If Item 27 is marked other then "hetural", or Iteme 23a or 28a-f ehow importent: If Item Medical Exercity ar must be notified at once. Maryland Montgomery Rockville 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6001 Muncaster Mill Road 20855 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jeffery Lorraine Rather Gerald M. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clare Delaney/ Daughter 1709 Gamewell Road, Silver Spring, MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Georgetown University Medical Center 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2006 4. Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, Inc. Signature of Funeral Service License P.O. Box 58007 Washington, D.C. 20037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Left Middle CerebralArtery CVA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Eaguer tially list on ultione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ŏ Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Type 2 Diabetes Mellitus has autopsy performed? Yes 2 ☑ No 1 Yes 2 No 1 ☐ Yes <u>Vascular Dementia</u> To the Hospital or Attending Physician: within 24 hours efter death.
To the Funerel Director; After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ÑNatural 1 TYes 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sutcide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 Homicide 15 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License number 4-4-2006 Cenikia m Dille H0058032 ol ano 6001 Muncas Rockville, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, M.D. 31. Date filed (Mosth, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

Thomas

PHYSICIAN:

KNOWN

NAME

06-06631 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Marcus Lee James 2006 Certificate of Death 1- For State Reg. No Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1850 hrs September 4, 2006 Medical Examiner Marcus Lee James 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number North East Cecil Route 272 south of Route 274 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. Date of Birth(MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) DE Months Days Hours Director 10-15-1979 1 X M 2 26 222-64-1707 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No or 28a-f show DE NewCastle Newark death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 19702 USA 5 Tahoe Ct. Apt. B-2Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: black Widowed Divorced If Yes, Give Year Yes 2 X No specify: hours after permit. Pages I and 2 should be filed within 72 hours after Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Me it al Ex.miner. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 accountant Emile Henry 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earlene Mazle Lee James Be Ronald James, Sr.

၉

19a. Informant's Name/Relationship (Type, Print)

James

Earlene

20a. Method of Disposition

25. Was case referred to medical

No

examiner?

1 V Yes

27. Manner of Death

Natural

Laron Locke MD.

**Physician** /Medical xaminer

Examiner this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial - transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical Division of Vital Records, P.O. Box 68760, ş Completed Be Certification: Medical

20a. Method of Disposition		Disposition (Name of certiletery,	Date	200. Education 2 City o	TOWN, State
1 X Burial 2 Cremation 3 Donation 5 Other Specify.	- Killow Bond Grace	ry or other place) lawn Memorial	9-12-2006	NewCastl	e,DE
21. Signature of Funeral Service Licen	Willed !!	The House of 208 E 35th	Wright M	ortuary	
23a. Part I. Enter the disease, or comp failure. List only one cause on ea	ach line.	t enter the mode of dying, such as o	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
100 100 - 10 - 4 100 V	Multiple Injuries  Due to (or as a consequence of):				Boun
cause. Enter Underlying Cause	Due to (or as a consequence of):  Due to (or as a consequence of):				
UNPENDED	AMENDED				
IF FEMALE:	23c. If yes, outcome of pregnancy	23d. Date of delive	ry		
23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2	Fetal death 3 Ectopi Other (Specify)	c pregnancy	Month	Day Year
Deat II. Other circuitions anditions	contributing to death but not resulting	in the underlying cause given in P	art I 23e. Did to	hacco use contribute to	the cause of death?

Tahoe Ct.

20b. Place of Disposition (Name of cemetery,

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Apt.B-2 Newark.

24a, Was an

Nursing Home 5

26.Place of Death (Check only one)

Other<sub>4</sub>

Yes 2 V No

28c. Injury at Work?

autopsy performed? ✓ Yes 2 N

28d. Describe how injury occurred

Motorcyclist in accident

DE

20c. Location - City or Town, State

Yes 2 ✓ No 3 Probably 4 Unknown

1 V Yes

Residence 6 V Other: Scene

24b. Were autopsy findings available prior to completion of cause of

19702

Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State determined Route 272 south of Route 274, North East, MD (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 5, 2006 O.C.M.E

31. Date filed (Month, Day, Year) SEP 1: 9 2006 State Registrar

Assistant Medical Examiner

Inpatient 2

28a. Date of Injury (Month, Day Year Sep 4, 2006

Hospital:

111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

cause of death (Item 23a)

ER/Outpatient 3

28b. Time of Injury

1846 hrs

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** eptember 2006 Ardelia J. Jeter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Carrollton Dew Nicholson St If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours 1 □ M 2 137 F Months Days 60 225-60-4238 Virginia June 19, Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10h County item 27 is marked other then "neturel", or items 23a or 28a-f shov other treumatic event, the Modical Examinar must be notified at XXYes 2 □ No Director New Carrollton Prince George's Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 U.S.A. 8315 Nicholson Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ②No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Black 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit, Pages 1 and 2 should be filed win Department of Health and Mental Hygient importent: if item 27 is marked other the any injury or other treumers Progurement Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Carey John R. Braxton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8315 Nicholson Street New Carrollton, Maryland 20784 19a. Informant's Name/Relationship (Type, Print) Yolanda Jeter (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Harmony Memorial Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State September 9, 2006 Landover, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CardioVASC Atheroscheretic Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence of Examiner signed by the attending physician and d be detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 ☐ Yes 2**X** No 1 Yes 2 No the Hospitel or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Inpatient 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 27. Mann eath 1 Natural 5 Pending 1 🗌 Yes 2 Accident investigation after death. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 24 hours a 1 Ceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who com leted cause of death (Item 23a) (Type, Print) 30. Name and address of person 3001 State SEP 0 8 2006 Registrar

			For State Ragistrar	State of Maryland / D	Department of Ho			ene 2006	30034
	Physici /Medio		1. Decedent's Name (First, Middle, Last,	HTI JOHN			2. Date of Death Month	Day Year	3. Time of Death /243 M
	Examir Funeral		4å. Fačility Name (If not institution, give  ININGUA LEGIONAL  5. Social Security Number 6. Se.	Madjust Intal x 7. Age (In yrs. last bin	thday) If Under 1 Year	If Unger 24 Hrs.	8. Date of Birth	4c. County of Deat	n /C/ hplace (State or Foreign
200	Director	1	2/3-74-60/6 10 Usual Residence of Decedent 10a. State 10b. County	M 200F 36	Yrs. Months Days	Hours Min.	(Month, Day, Y	70	10d. Inside City Limits
	with the Marylend a or 28a-f show be notified at	Director	MD WICOM  10e. Street and Number	nco SA	LISBURY 101. Zip Code		10g	. Citizen of What Co	1 □ Yes 2 ☑ No
) (0	death	Funeral Director	32125 - JOHNSO  11. Marital Status  12. Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes, 2 No If Yes, Give	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto F	offy Yes or No- lican, etc.)	14. Race - Ame Black, Whit	e, etc.
15-0036	in 72 hours after n"netural", or Ite	Completed by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	rear or Dates: lication le completed) 16a.	1 ☐ Yes 2 ☑ No  Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)	Specify: tion uring most of workin		Specify: 656b. Kind of Business	
nd 2121	12 should be filed within ? h and Mental Hygiene. 7 is marked other then ". traumatic event, the Med	Be Comp	17. Father's Name (First, Middle, Last)	1 _	NESTICVICLEN	0.0	INATOR -	SHERIFF!	~ /-
Maryland	2 should land and Menion la market	2	HOLL E  19a. Informant's Name/Relationship (7)	MAN	. Mailing Address (Street a		-	542115	
altimore, N	ages 1 and 2 ant of Health ht: If Item 27 I y or other tra		20a. Method of Disposition  1 Structure 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. Place of cemeter	Disposition (Name of ry, crematory or other place	)	SAUSBU ate 20	ic. L + tion - City or	Town, State
Baltin	permit. Page Depertment of Importent: If any Injury or once.		21. Sign ture of Funeral Service Livens		GHILL MENO 22. Name an Address 912.W.I.	s of Facility BE	NNIE S		ERAL HOME D 21801
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. RespirA 18		, such as cardiac or	respiratory arres	ı, //	Approximate Interval Between Onset and Death
8760,	te be executed with the beautied with the burial-transit and the bur	ilcal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pu(mona)  Due to (or as a consequence of the con	o f.				VA 100
O. Box 6	eath certific ettending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of del Month	ivery Day Year
ords, P.O.	n requires that the diben signed by the should be detached	ed by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in		n in Part I.	23e. Did toba	3/	the cause of death?
Division of Vital Records,	The law ate hes b page 2 sh	Completed by					24a. Was an autopsy performe 1 Yes 2	prior to death?	itopsy findings available completion of cause of 2 No
f Vit	Physiclan: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No		tpatient 3 DOA Othe	26. Place of Death  C. 4 Nursing Hom		ce 6 Other (Spe	cify)
ision o	the f	Certification:	27. Manner of Death  1. Natural 2 \( \) Accident 3 \( \) Suicide  6 \( \) Could not be	(Month, Day Year)		es 2 □No	8d. Describe how	injury occurred et and Number or Re	iral Roule Number
Ο̈́	To the Hospital or Attending I within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	sal Certi	4 Homicide determined  29a. Certifier 1 Cartifying Phy (Check only 2 Madical Exami	building, etc. (Specify)  sician: To the best of my knowledge	e, death occurred at the time	e, date and place, a	City or Town,	State) se(s) and manner as	stated.
	To the He within 24	Medical	29b. Signature and title of certifier	ompleted cause of death (Item 23a)  32. Register's Signature  2006	d/or investigation, in my op	number	d at the time, date	and place, and due  Date signed (Mont	h, Day, Year)
-	trak		30. Name and address of person who co	ompleted cause of death (Item 23a)	(Type, Print) MILAND ST.	SALISBUR	ry mo		
	Sta "Regist	ate rar	31. Date filed (Month, Day, Year) AUG 3	32. Registra's Signature	G. Sparke		/		

			For State Registrar	State of Marylar	-		nt of Health		-	giene 19g. No.	200	6 30	035
	Physici	an	Decedent's Name (First, Middle, Las						2. Date of Dea Month	ith Day	y Year	3. Time of	Death
Same Co.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			Town, or Location		Septem		County of Dea	th	5 P <sup>M</sup>
	Funeral Director		Shady Grove Adve 5. Social Security Number 6. So 579-62-1929					ler 24 Hrs.	8. Date of Birth (Month, Day April 1	, Year)		omery thplace (State country) Labama	r Foreign
	Maryland f ahow	lor	Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll		y, Town or Lo							10d. Inside C	ity Limits 2 □ No
	h with the 13e or 28a-	al Director	10e. Street and Number 1112 North Main				21771		1		zen of Whal C	ountry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "naturel", or items 23e or 28e-f ahow any injury or other treumatic avant, the Medical Examinar must be notified at ODGe.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Novidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Dece if Yes, spe 1  Yes	dent of Hispanic of Cuban, Mexico 2 No Special		ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi	te, etc.	
1215-0036	within 72 hou ene. than "nature ha Madical E	Completed	15. Decedeni's Ed (Specify only highest graded) Elementary/Secondary (0-12)		(Give	dent's Usu kind of we DO NOT L	al Occupation ork done during m ise retired)	ost of work	ing		nd of Business		
Maryland 2121	ould be filed Mental Hygi arked other atic avant, t	To Be Co	17. Father's Name (First, Middle, Last) Will Walker	r	1100		18. Mo	ther's Name Gladys	e (First, Middle, 1	Maiden			
, Man	and 2 sho salth and I n 27 is mu er treums		19a. Informant's Name/Relationship (7 Heather LaShawn I			•	s(Street and Num orth Mai						:1771 l
altimore,	Pages 1, nent of He int: if Itan iry or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Dispo cemetery, cren iendsh	natory or	me of other place) emetery	 			cation - City of Damascu	Town, State	·land
Balti	permit. Departn Imports any inju		21. Signature of Fune al Service Con	William			nd Address of Factorial Ridge Re						
)	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the deat one cause on each line.  Myocardial a	h. Do not ent	er the mo	de of dying, such	as cardiac o	or respiratory arr	est,		Approximat Interval Bet Onset and I UNKNOW	e ween
	/Medical Examiner		Sequentially list conditions	Due to (or as a consequence of):  Sepsis  Due to (or as a consequence of):							2 Week	is	
o,	cate be executed physicien and the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
68760	fficate be physicie ts the bu	edicai		d									
P.O. Box	law requires thet the death certificate be executed es been signed by the attending physicien and 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic p Other (s)				4	23d. Date of de Month		Year
	w requires thet been signed b should be deta		Part II. Other significant conditions on End-Stage Renal		ulting in the u	nderlying	cause given in Pai	rt I.			se contribute t	o the cause of d	leath? Jnknown
Il Records,	The ate h page	Completed	Diabetes Hypertension						24a. Was a autops perform	sy	death?	utopsy findings completion of c	available ause of
Vital	Physician: r this certific ral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ∑Xinpatient 2 □	ER/Outpatien	a 3 □ D0	Othor		n <i>(Check only on</i>		S □Other (So	icitu)	
sion of	ing P	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)						Residence 6 Other (Specify) cribe how injury occurred			
Division	i te o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specif	y) 		200-20		28f. Location (St City or Town	n, State,	)		ber.
	To the Hospitel or within 24 hours after To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exem	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred vestigation	at the time, date i, in my opinion, d	and place, leath occurr	and due to the cared at the time, d	ause(s) late and	and manner a place, and du	s stated. to the cause(s	)
)	To th Withir To th	M	29b. Signature and title of certifier			29	D58681	ər	2		e signed (Mon	th, Day, Year)	006
	10		30. Name and address of person who of Jude Alexande	completed cause of death (Item		,	ter Driv	re. Ro	ckville	Ma	rwland	20850	
	Sta Registr		31. Date tiled (Month, Day, Year) SEP 0 6 2	32. Paistrar's Signa	ture			J, 10		, 110	тулани	20000	

			For State of N  1 - State Registrar	Naryland / Depa <i>Cer</i>	artment of H rtificate of L	ealth and N D <i>eath</i>	fental Hyg	iene 200	6 30036	
	Physicia		1. Decedent's Name (First, Middle, Last)  David Leroy King				2. Date of Deat August 3	th 30 Day 2006 Year	3. Time of Death 11:55 а м	
1	/Medical 4a. Facility Name (If not institution, give street and number) Charles County Nursing & Rehab					Location of Death		4c. County of Death Charles		
	Funeral Director		X	Age ( <i>In yr</i> s. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 16	9. Bir	thplace (State or Foreign ountry) aryland	
	aryland show		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
the Ma	r 28a-f	recto	Maryland Charles  10e. Street and Number	Bryans R	load 10f. Zip Code		1	log. Citizen of What C		
	th with	al D	7070 Detroiter Place		2061	16		U.S.A.		
036	within 72 hours after death with the Maryland sne. Then "natural", or iteme 23a or 28a-f show he Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Deceder Armed Force  1 Yes, Give Year or Dates	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)			
21215-003	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-40	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work	king	16b. Kind of Business	,	
Maryland 2	should be filed within of Mental Hyglene. marked other then "	o Be Co	17. Father's Name (First, Middle, Last) William Robert King				e (First, Middle, I	Maiden Sumame)		
Mary	and 2 should eath and Men n 27 is marke	-	19a. Informant's Name/Relationship (Type, Print) Brenda Utt Daughter		ng Address (Street a			r, City or Town, State, Md. 20646		
altimore,	iter of H		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Oakland		Sept. 2		20c. Location - City on Waldorf, 1		
Balti	permit. Page Depertment of Important: If ony injury or once.		21. Signature of Funeral Service Lio	M00668 Wi	Name and Address 1111ams Fi 270 Hawtho	ss of Facility ineral Ho orne Rd.,	me, P.A. Indian	Head, Md.	20640	
	Physician		23a. Part 1. Enter the disease, or complications that taused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Terminal Aspiration Pneumonia  Approximate Interval Between Onset and Death 2 Weeks							
J.	/Medical Examiner		resulting in death)  Due to (or a	as a consequence of):						
O, executed en and rial-transit	icate be executed physicien and it the burial-transit	1 Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a							
68760,		ledical	d			-viida				
P.O. Box	at the death certific by the attending p tached for use es i	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   3   Ectopic pregnancy   Mc						olivery Day Year	
	quires that I n signed by uld be deta	þ	A 1—h a import a Domont is a						o the cause of death?	
Reco	The law requires that the sete has been signed by the page 2 should be detache	Completed	Neuropathy	24a. Was a autops perform	med? death?	utopsy findings available completion of cause of				
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?		100		th (Check only on	10)		
Division of Vital Records,	ng Phye Iter this	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Inpa	f 28c. Injun Worl	her: 4 Nursing Home 5 Residence 6 Other (Specify)  ry at 28d. Describe how injury occurred rk?  1) Yes 2 No			ecity)		
Divisi	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:	action of Could not be	Injury - At home, farm, str etc. (Specify)	reet, factory, office			tural Route Number,		
	e Hospit	Medical O	29a. Certifier (Check only one)  1 Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examination and/or in	h occurred at the time vestigation, in my o	ne, date and place, pinion, death occur	and due to the corred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier	0	29c. Licensi D5545.		2	9/8/2006	th, Day, Year)	
8	B1		30. Name and address of person who completed cause of Fatima Hussein, M.D., 56	f death (Item 23a) (Type, 25 Allentowr	Print) n Rd., Su	it 101, (	Camp Spr	ings, Md.	20746	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Rg	strar's Signature	post			448		

			For State	State of Ma	ryland / D	epartmer Certifica	nt of H	ealth and N Death		jiene 2   leg. No.	J U 6	30037
			Registrar  1. Decedent's Name (First, Middle, Last)				0, 1		2. Date of Dea			3. Time of Death
	Physicia	an		ong					Month 09	Day -	2006	1255 M
	/Medic		4a. Facility Name (If not institution, give s			4b. City	Town, or	Location of Death		1	y of Death	
	Examin	er	Coursela Coursel NA	de la	111		5	alisbuM	•	N	leon 1	10
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birth		r 1 Year	If Under 24 Hrs.	8. Date of Birth	)	9. Birthp	ace (State or Foreign
	Director		226-60-8643	M 2□F	60 Y	rs. Months	Days	Hours Min.	(Month, Day 01-03-1	946	Washi	ngton D.C.
Ţ			Usual Residence of Decedent									
rylan	ehow id at	_	10a. State 10b. County		10c. City, Town	or Location					119	0d. Inside City Limits 1 Yes 2 □ No
e Ma	Na-f	cto	MD Somerset		Princ	ess Anr	ie					
iš S	or 20	Director	10e. Street and Number			10f. Zi	p Code	_	,	10g. Citizen of		try?
ath w	23a	rai	30444 Linden Avenu				2185				SA.	
er de	tems in m	Funeral	THE MAIN STATES	12. Was Decedent E Amned Forces?		13. Was Dece	ident of Hi scify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		ce - Americ ack, White,	
Safte	o'.	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Maryes 2 □ N If Yes, Give Year or Dates: V		1 🗆 Yes	a No	Specify:		Speci	fy: Wh	ite
	tural		15. Decedent's Educ		16a. [	Decedent's Usi	ial Occupa	ation		16b. Kind of B		
22 Li	an . u	Completed	(Specify only highest grade	completed)		(Give kind of w life. DO NOT	ork done d ise retired	luring most of worl )	king			,
M M	there.	E	Elementary/Secondary (0-12)	College (1-4or 5- none		Technic	ian			Teleph	none C	ompany
ind Z i Z i 3-0000 be filed within 72 hours after death with the Maryland	othe ent,	BeC	17. Father's Name (First, Middle, Last)		- '-			18. Mother's Nam	ne (First, Middle,	Maiden Suma	me)	
<u>a</u>	Med ice	To B	Leroy Long, Jr.					Mildred	McGlynn			
should	Department of Health and Mental Hygiene. Important: or items 23a or 28a-f ehov Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehov any injury or other traumatic event, the Medical Examiner must be notified at once.	<b>F</b>	19a. Informant's Name/Relationship (Type	pe, Print)	19b.	Mailing Addres	s (Street a	and Number or Ru	ral Route Numbe	r, City or Towr	, State, Zip	Code)
and 2	alth a 27 i 27 i r tre		Maureen Collins Lo	ong/Wife	304	444 Lin	den A	ve., Pri	incess A	nne. M	2185	3
– ע	item oths		20a. Method of Disposition		20b. Place of I	Disposition (Na	me of	!	Date	20c. Location	- City or To	wn, State
Pages	nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	ury Cre			-2006	Salish	oury,	MD
Daillino	partn ports y inju	1	21 Signature of Funetal Service License	эе				s of Facility				
0 8	Depar Impor	(	MARS X NOLINA	M) - MO	0295			eral Home cset Ave.		ess Ann	e. MD	21853
			a. Part1. Enter the disease, or complishock, or heart failure. List only do	carions that caused	the death. Do no	ot enter the mo	de of dying	g, such as cardiac	or respiratory ari	rest,	,	Approximate Interval Between
P	hysician	103	mmediate Cause (Final disease or condition	Acu	TE /	DNEU	Mo	NIA				Onset and Death
	/Medical	4	resulting in death)	1	consequence o				,			
Ε	xaminer		A	META	STATIC	SN	ALL	CELL	LUN G	CAN	CER	IMEAR
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence o	f):						
cuted	nd Iransi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	·								
O, o	ian a urial-i	Ä	resulting in death) Last	Due to (or as a	consequence o	f):						
fords, P.O. Box 66/60,	physician and the burial-transit	dical		i							-	
or diffe	ingp	Med	IF FEMALE:	0- 14	4	A THE STATE	-	- 1	outille-se-			
XOU THE	ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth	2 Fetal death	3 ☐Ectopic					ate of delive Ionth	ry Day Year
. 4	the e	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (s	респу)					
	d by Jetac	F.	Part II. Other significant conditions cor	ntributing to death bu	it not resulting in	the underlying	causa dive	an in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of death?
cords,	signed b	1 by	HYPERTEN		•	,,	•		1 🗆 🗸	es 2 No	3 🗌 Prob	ably 4 □Unknown
	houle	etec		DIABE	TEC	ME	1 1	1740	04- 146-		14/	
The law	has l	Completed	1712	2 171 50	· · · ·	1110	<u></u>		24a. Was autop	sv	prior to cor death?	psy findings available apletion of cause of
E 1	cete								1□ Yes	2 No	1 Yes	2□ No
OT VITA	certif	Be	25. Was case referred to medical examiner?	lospital:			Other	er	th Check only o			
5 8	this aldi	-T	1 Yes 2 No	1 Minpatie			UA	4 Li Nursing n	ome 5 Resid			"
בַּ	Alter	lon	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) In	jury M	28c. Injury Work	k? Yes 2 □ No	252. 5 550.155 1.	on anjury cood		
	deatl ctor: / the	lca	3 Suicide 6 □ Could not be	28e. Place of Inju	ırv - At home, far				28f. Location (S	Street and Num	ber or Rura	I Route Number,
DIVISION OF	Dire	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)		.,,		City or Tow	m, State)		
- 6	ours nerai		29a. Certifier 1 Certifying Phys	sician: To the best of	of my knowledge,	death occurre	d at the tim	ne, date and place	, and due to the o	ause(s) and n	nanner as si	ated.
1	E Fui	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner sta	examination and ted.	Vor investigation	n, in my o	pinion, death occu	rred at the time, o	date and place	, and due to	the cause(s)
Š	The fraging of the family fraging is a special of the family fraction, page 2 should be detached for use as	Me	29b. Signature and title of certifier	4		2	c. License	e number	2	29d. Date sign	ed (Month,	Day, Year)
	0			1 de	54	11/10	D	469	162	SEPTE	EM136	ER 04,2006
			30. Name and address of person who come and address of person who	ompleted cause of de	eath (Item 23a) (	Type, Print)	D-	FILE ALA	MEDI	(A1 C	ENT	En.
			M, SHIPAZI,	M.D. P.	ENIN-	SULA	156	910101	L . 1021		MD	21081
7	Sta Registi		31. Date liled (Month, Day, Year) SEP 0 6 21	32. Redistra	ar's Signature	Sugar	8,					

State of Maryland / Department of Health and Mental Hygiene, 30038 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Rosetta Bernice Leonard 2240 30,2006 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Easton Hospital <u>Talbot</u> Memorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 7 (Manth. Pay. Year) Age (In yrs. last birthday). 90 Yrs. 9. Birthplace (State or Foreign Social Security Number 218-16-6723 **Funeral** 1□M 2XF Indiana Director Usual Residence of Decedent deeth with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Show Md Talbot St. Michaels 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with neat of Heelih and Mentel Hygiane. and I flem 23 is marked other then "naturel", or items 23a or ury or other traumatic event, the Medical Examinar must be ury or other traumatic event, the Medical Examinar must be a 21663 104 Miles Lane #112 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ Xio If Yes, Give Year or Dates: 1 Never Married 2 Married osetta Leonard more, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify White Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietetic Supervisor Hospital 11 years year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert F. Sweitzer Lois O. Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry D. Leonard (son) 29968 Dover Rd., Easton, Md. 21601 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20b. Place of Disposition (Name of olivet Cemetery 9-6-2006 St. Michaels, Md. permit. Page Depertment Importent: if any injury o 4 ☐ Donation 5 ☐ Other (Specify)  $^{22.\;\text{Name and Address of Facility}}$  R. Carroll Hurley Funeral Home, PC 21. Signature of Funeral Service Licensee 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nydva **Physician** 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Obstruction 1 Yes 2 No 3 Probably A Unknown Singl Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice 25. Was case referred to medical Be 28. Place of Death | Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Tes 2 No After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No 2 Accident investigation Certificat 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -2-Dennis DeShields, Md. 219 S. Washington St., Easton, Md. 21601 31. Date filed (Month, Day, Year) 32. Reģistrar's Signature State SEP 05 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State o	f Marylan	•	artment of H		Mental Hygie	ne No2006	30039
	Physici	an	1. Decedent's Name (First, Middle,		_				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	ai	RONNIE  4a. Facility Name (If not institution,	L.		YLES	4b. City, Town, or	Location of Deat	Sept.3,	2006 4c. County of Death	3:15P M
E	Examin	ier	Casey House	9/10 011 001 = 10 110	20.7			ville		Montgom	
	Funeral Director		5. Social Security Number 216-64-0911	S. Sex f M 2 ☐ F	7. Age (In yrs. 5 2	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month Day Ye	9. Birth Cou	place (State or Foreign ntry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Maryl	tor	MD Mont	gomery		Dam	ascus				1⊠Yes 2□No
	3a or 28s	Il Director	10e. Street and Number 9501 Holsey	Rd			10f. Zip Code 20	872	10g.	Citizen of What Cou	ntry?
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "naturel; or iteme 23a or 28a-f show ematic event, the Modical Examinational be notified at	y Funeral	11. Marital Status  1 XNever Married 2 Marne 3 Widowed 4 Divorced	Armed Fo	2 <b>23</b> No		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: B]	etc.
9	2 hour	ted b	15. Decedent's	Education	ates:	16a. Deced	ient's Usual Occup	ation	168	b. Kind of Business/Ir	
215	ithin 7.	Completed by	(Specify only highest Elementary/Secondary (0-12)	College (	1-4or 5+)		kind of work done of DO NOT use retired dscape			Private	2
d 2	filed w Hygier Sther ti	e Co	10th 17. Father's Name (First, Middle, L	ast)		Lan	uscape		ne (First, Middle, Mai		
/lan	Mental Mental arked c	To B	Charles N.	Lyles				Kath	erine Po	rter	
Maryland 21215-0036	permit. Pages 1 and 2 should be Deperment of Health and Mental Important: If Item 27 is marked eny injury or other treumatic work injury or other treumatic works.		19a. Informant's Name/Relationshi Charles Lyles		ther	1	-		ural Route Number, C. Gaithers		
Baltimore,	of Hee		20a. Method of Disposition  120 Burial 2 ☐ Cremation	3	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place	θ)	Date 200	. Location - City or T	own, State
Ē	ortment:		4 □ Donation 5 □ Other (So 21. Signature Funeral Service	ecify)			hip Cem		3/06 D nowdenFun	amascus,	
Ba	Deperiment of the periment of		trange K.	Haon	tely A				on St Ro		•
B			23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final						or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	d	astati (or as a conseq		g Cance	r			
	Examiner	-	Sequentially list conditions,	b. — Other for	(or as a conseq	IMPORTO					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	,0						
760,	tte be executed sysicien and he burial-transit	Ical Ex	resulting in death) Last	Due to	(or as a conseq	uence of):					
687	g phys as the			d.						i	
P.O. Box	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live I	tcome of pregna pirth 2 ☐ Feta nant at time of d own	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	reny Day Year
	w requires that been signed b should be deta	6	Partil Other significant condition Type II Diabe			ulting in the u	nderlying cause giv	en in Part I.	4 4 1 1 1 1 1 1 1	co use contribute to	the cause of death? bably 4 □Unknown
Division of Vital Records,	Physicien: The law re this certificate has bee al director, page 2 sho	Completed							24a. Was an autopsy performed	i?   death?	opsy findings available ompletion of cause of
/ita	Physicien: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Ha-ia-ti			101		ath (Check only one)		
ō		2	1 ☐ Yes 2 🔯 No 27. Manner of Death	Principle of the Control of the Cont	Inpatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time of			dome 5 Residence		<sub>(y)</sub> Hospice
ion	Attending For death.  ector: After by the funera	atlor	1 Accident 5 Pending investigation	ition	th, Day Year)	Injury		k? Yes 2 □ No			
<u>X</u>	2	Certification:	3 ☐ Suicide 6 ☐ Could no determin	200. Place	of Injury - At he ing, etc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hoepital of within 24 hours all to the Funerel D completely filled in	Medical C	29a. Certifier 1 Cartifying (Check only one) 1 Madical E	xaminar: On the b	e best of my kno easis of examina ner stated.	wiedge, deatl tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier	2- W.	0.4		29c. Licens			Date signed (Month.	
E	3 (1)		30. Name and address of person w	m Shu				5803	2	9-4-20	106
			Cynthia M. Wi	lliams,	DO 60	01 Mu	ıncaster	Mill I	RD Rockvi	lle, MD	20855
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6	2006	Registrar's Signa	ture for	we				

			For State	State of Ma	ryland	•	artment of H		lental Hygier Reg. 1	71116	30040
			Registrar  1. Decedent's Name (First, Middle, Last,	)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	2. Date of Death		3. Time of Death
	Physicia	an	ROSCOE	AUSTIN	LEWIS	S S1	R.		September	13 2000	715 PM
	/Medic Examin		4a. Facility Name (If not institution, give					Location of Death		4c. County of Death	1
	LAGIIIII		Fahrney Keed	4 Memo	rial.	Hom	e Boo	insbora		Wash	ington
y.	Funeral		5. Social Security Number 6. Se		(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place State or Foreign intry)
	Director		219-12-16/2	] <b>M</b> 2□ F	84	Yrs.			July 15,	1922   Mar	yland
	pur *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or La	cation				10d. Inside City Limits
	farylis sho	5		-1-							1 □ Yes 2√No
	289-1	Director	Maryland Frederi  10e. Street and Number	CK	мує	rsvi	10f. Zip Code		10g.	Citizen of What Cou	untry?
	with Sa or		11420 Pleasant Wal	k Road			21773			USA	7
	ns 23	100	11. Marital Status	12. Was Decedent E	ver in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
98	J within 72 hours after death with the Maryland jiene Than "natural", or Itams 23a or 28a-f show The Madical Exacilinal cust be notified at	y Fur	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1	О		nrYes, specnny Cuba 1 □ Yes 2√⊋ No	Specify:	rican, etc.)	Black, White	hite
8	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates: 1	<u> 1940–4</u>		dent's Usual Occup	ation	16b	. Kind of Business/I	
7	"nat	Completed	15. Decedent's Edu (Specify only highest grad			(Give	kind of work done of DO NOT use retired	ation during most of work f)	ing	, Killa of Business/i	ndustry
7	withii ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5	+)		eman			wer Suppl	Ly Company
<u>0</u>	Hyg Hyg ant,	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
Maryland 21215-0036	To the second	To B	Edward		]	Lewis		Annie		Hime	es
ar)	8 8 9		19a. Informant's Name/Relationship (T				-		al Route Number, Cit		
	Health Health tam 27 I		Kathleen Lewis/wi	.fe							ryland 21773
ore	Pages 1 nent of Hi int: if itan		20a. Method of Disposition 1   □ Burial 2 □ Cremation 3 □ I	Removal from State	cen	netery, crei	osition (Name of matory or other place	:e)		Location - City or	
Ē	ment tant:		' 4 ☐ Donation 5 ☐ Other (Specify		Pleas						, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signatury of Funderal Service Licent	000			2. Name and Addre	<i>'</i>	- · · · · · · · · · · · · · · · · · · ·	iin Street ville, MD	
	46540		232 Part I Pater the disease of comp	lications that caused	the death		cketts Fu			Tite, m	Approximate
			23a. Part 1. Inter the disease, or comp shock or heart failure. List only of Immediate Cause (Final	ne cause on each lin	2			9, 00011 00 001 0110	,,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a	neur						
	Examiner			Due to (or as	a conseque	nce or):					
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	nce of):			·····		
1	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a conseque	nce of):					
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai		d							
9	ntifica ng ph as th	Med	IF FEMALE:								
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal d	eath 3[	Ectopic pregnancy	,		23d. Date of deli Month	very Day Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	th 5L	Other (specify)				
P.0	that the de led by the a detached	Ph	Part II. Other significant conditions or	entributing to death be	ut not result	ing in the u	inderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Records,	26 PB	d by	1 2 12 50						1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Anknown
Sor	w require been signal	iete							24a. Was an	24b. Were au	topsy findings available
Re	sician: The law certificate has b irector, page 2 s	Completed							autopsy	I? death?	completion of cause of 2 No
Vital	ificate	e C	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes 2 ☐	NO THES	2 140
>	Physician: this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatie	nt 3 DOA Oth	on .	ome 5 Residence	e 6 ☐ Other (Spec	pify)
of			27. Manner of Death	28a. Date of Inju	ry 2	8b. Time o	of 28c. Injur	y at k?	28d. Describe how i	njury occurred	
ō	Mtandin death. ctor: Aft y the fun	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation		, , , ,	injury		Yes 2 □No			
Division	for Atta after de Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, et	ury - At hom c. (Specify)	e, farm, st	reet, factory, office		28f. Location (Stree City or Town, S		iral Route Number,
Q	itato irsaft ral Di led in										
	To the Hospital or Attanding within 24 hours after death.  To tha Funaral Diractor: Afte completely filled in by the fune	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example one)	ysician: To the best mer: On the basis of and manner sta	f examination	edge, dea n and/or ir	th occurred at the time to the street of the	me, date and place prinion, death occu-	and due to the caus red at the time, date	e(s) and manner as and place, and due	to the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and title of pertiner				29c. Licens	e number	29d.	Date signed (Monti	h, Day, Year)
	> - 0						D	5036	a l	September	15, 2006
L	\		30. Name and address of person who	completed cause of d	leath (Item 2	23a) (Type	Print)			10 - 10	702
	1		Vincent A. Canto	100				d., Smith	sburg, Man	ryrand 21	
* C		ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	r <b>é</b>	JOHN J				
	. Regist	rar	SEP 2 1 2	000 /4 300	N-82,00gs, FS	E EE					

State of Maryland / Department of Health and Mental Hygiene 200630041 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Armand 9:57 /Medical Landry 08-30-2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27685 Polo Court Salisbury Wicomico If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Months 1∭M 2□F Director 033-14-1628 86 12-11-1919 Brockton, MA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or iteme 23a or 28a-f ehow Examiner n'unt be notified at Director 1X Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27685 Polo Court 21801 Pages 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "neturel", or Iteme 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? I 948-1 M Yes 2 □ No 1955 If Yes, Give Year or Dates: Air Force 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Landry / Father Alexena LeBonte/Mother 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Landry/Daughter 27685 Polo Court, Salisbury, Milaco of Disposition (Name of 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmar 09-06-2006 Delmar, DE 21. Sgnature V Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that cars shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician MINS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Records, 1 🗌 Yes 24 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy rmed? 1 Yes Division of Vital fo the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural 1 Yes 2 No investigation death. hours after death unerat Director: / ly filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Vithin 24 hours are:
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Die AL 30. Name and address of person mpleted cause of death (Item 23a) (Type, Print) PoBox DONALD M. State 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 30042 1 - For Stete Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OP **Physician** 0936 AM 2004 Daniel3 HARLES /Medical 4c. County of Deeth 4b. City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N4h risfield 36 omerset If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 M 2 ☐ F 99-34-2759 01-10-194 + bila Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at risfield 1 Xes 2 No Director >Omerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 21817 or Items 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 PYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 Ho Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) y/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. College (1-4or 5+) cterar Hisable 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MC Janiels rude Un Known 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21817 4th ST. MD risticld Health item 27 Lula Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1
Department of the Importent: If ite eny injury or ot once. 1 Surial 2 Cremation 3 Removal from State VEteran Comeley -06 09-05 Thu lock 4 □Donation 5 □ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service License asp Funcial Home 21817 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition cell CA 3 mall **Physician** 6 MO Nou resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 XYes 2 □ No Be Compieted 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has I autopsy performed? 2 No To the Hospital or Attending Physicien: 26. Place of Death (Check only one) director. 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural
2 Accident Injury 5 Pending after death. 1 Tes 2 No investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Thomicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License numbe 29b. Signature and title of certifier D0014-314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Condit strut, Solis bury. MD. 21801 KLUA. 145 PANPIT 32. Regist s Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

Alice Morgan

	•	1 - For State Registrar		(	Certificate of	Death		Reg. No.20	06	<u> 3004</u>
Physici	an	Decedent's Name (First, Middle					2. Date of Dea Month	ath Day	Year	3. Time of Death
/Media	cal	ALICE GRACE N			45 Ch. Taua		Sept	3 20 ( 4c. County		7:48 AM
Examir	ner	4a. Facility Name (If not institution, Genesis Healt	-			or Location of Dea ston	uri		albo	+
uneral		5. Social Security Number	6. Sex 7.	. Age (In yrs. last birth		r If Under 24 Hr		h	9. Birth	place (State or Forei
irector		219–46–7667 Usual Residence of Decedent	1 □ M 2 😿 F	93 Y	rs.	110010	APR 30	, 1913	MAR	ŸĹAND
Mo II	}	10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limi
Department of result and wester rigidate.  Department of the marked and the than "neturel; or liems 23e or 28e-f show many injury or other treumatic event, the Medical Examiner must be notified at once.	ctor	MD TA	ALBOT	E	ASTON					X Yes 2 □ N
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
8 23e	ral	610 DUTCHMANS	LANE	lent Cons in U.C.	10 Was Davidson of	21601	Consider Ven or No	14 Pag	USA	can Indian,
Them Them	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri	Armed Forc	es?	13. Was Decedent of If Yes, specify Cul		rto Rican, etc.)	Bla	ck, White,	
el', or	b	3 XVidowed 4 ☐ Divorced	If Yes, Give Year or Date		1 ☐ Yes 🛣 No	Specify:		Specif	WHI	TE
dical	Completed	15. Decedent (Specify only highes			Decedent's Usual Occu Give kind of work done	a during most of w	orking	16b. Kind of B	usiness/In	dustry
hen e Me	dw	Elementary/Secondary (0-12)	College (1-4	10r 5+)	life. DO NOT use retire	ed)		OT DY 1	TOME	
ther t		12 17. Father's Name (First, Middle, I	0		HOMEMAKER	18. Mother's Na	ame (First, Middle,	OWN I		
rked c	To Be	GEORGE E. WEED	, SR.			GERT	RUDE E. I	RIGGLES		
ie ma	_	19a. Informant's Name/Relationsh			Mailing Address (Stree				State, Zip	Code)
m 27 her tr		MARY MICHAEL/D	AUGHTER		O BOX 75,	ST. MICH	-		A1: =	
or oth		20a. Method of Disposition 1   Burial 2 □ Cremation		tate cemetery	Disposition (Name of crematory or other plane		Date	20c. Location		
rient	l n	* 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I		CEDAR	HILL CEMET  22. Name and Addr		11/2006	SULTLA	AND,	MARYLAND
Impo any i		1 21 (	)		EZ. HADITIO BITC MOUT			NAM TITM	TDAT	HUME DY
			Strocki C.	ESA	FELLOWS,	HELFENBE	TN & NEW	MENT FUNI	6NAL	HOFIE IA
		23a. Part1. Enter the disease, or	STROUSE C., complications that cau	used the death. Do no	200 S. HA	HELFENBE ARRISON S	T EASTON	, MD 210	601	Approximate
rsician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that cau	ch line.	200 S. HA	HELFENBE ARRISON S	T EASTON	, MD 210	601	Approximate Interval Between
ledical		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	ch line.	200 S. HA	HELFENBE ARRISON S ring, such as cardia	T EASTON	, MD 210	601	Approximate Interval Between
ledical		23a. Part1. Enter the disease, or shock, or heart failure. List of the disease or condition resulting in death)	a	ch line.	200 S. HA	HELFENBE ARRISON S ring, such as cardia	T EASTON	, MD 210	601	Approximate Interval Between
ysician ledical aminer	niner	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of the	a	ch line.	200 S. HA	HELFENBE ARRISON S ring, such as cardia	T EASTON	, MD 210	601	Approximate Interval Between
ledical aminer	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of the disease or condition resulting in death)	a	r as a consequence of	200 S. HA of enter the mode of dy  self lawer  self la	HELFENBE ARRISON S ring, such as cardia	T EASTON	, MD 210	601	Approximate Interval Between
ledical aminer	Ä	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of the	a	r as a consequence of	200 S. HA of enter the mode of dy  self lawer  self la	HELFENBE ARRISON S ring, such as cardia	T EASTON	, MD 210	601	Approximate Interval Between
ledical aminer	Ä	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consequence of	tenter the mode of dy  selized  by lower  saler de	HELFENBE ARRISON S ring, such as cardia	T EASTON	, MD 210	601	Approximate Interval Between Onget and Death Mary
ledical aminer	Ä	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock	a	r as a consequence of	200 S. HA of enter the mode of dy  self lawer  self la	HELFENBE ARRISON S ring, such as cardia Parties.	T EASTON	, MD 210	601	Approximate Interval Between Onset and Death Australia Constitution of the Constitutio
ledical aminer	Ä	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of the	a. Due to (o)  c. Due to (o)  d. 23c. If yes, outco	ras a consequence of as a consequence of a consequence	tenter the mode of dy  state of the mode of the mode of dy  state of the mode of the mode of dy  state of the mode of the	HELFENBE ARRISON S ring, such as cardia Parties.	T EASTON	, MD 210	601	Approximate Interval Between Onset and Death Must Superior States
ledical aminer	Ä	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock	a	ras a consequence of the same of pregnancy the 2 Fetal death with the same of the	200 S. HA  It enter the mode of dy  State of the second of	HELFENBE ARRISON S ring, such as cardia Partient Sease alizand	T EASTON	23d. Da	te of deliventh	Approximate Interval Between Onset and Death August Such Such Such Such Such Such Such Such
gned by the attending physician and in a detached for use as the burial-transit in the control of the control o	by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock of the shoc	a	ras a consequence of the same of pregnancy the 2 Fetal death with the same of the	200 S. HA  It enter the mode of dy  State of the second of	HELFENBE ARRISON S ring, such as cardia Partient Sease alizand	T EASTON ac or respiratory ar	23d. Da	te of deliventh	Approximate Interval Between Onset and Death August Support Su
been signed by the attending physician and uppersonal be detached for use as the burial-transit and the betached for use as the burial-transit.	by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock of the shoc	a	ras a consequence of the same of pregnancy the 2 Fetal death with the same of death with th	200 S. HA  It enter the mode of dy  State of the second of	HELFENBE ARRISON S ring, such as cardia Partient Sease alizand	23e. Did to	23d. Da Mc  obacco use conf  yes 2 \( \sigma \) No  an   24b.	tribute to t	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset Interval Between Onset Interval Between
as been signed by the attending physician and upon the burial-transit of should be detached for use as the burial-transit of the bur	by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock of the shoc	a	ras a consequence of the same of pregnancy the 2 Fetal death with the same of death with th	200 S. HA  It enter the mode of dy  State of the second of	HELFENBE ARRISON S ring, such as cardia Partient Sease alizand	23e. Did to	23d. Da Mc  23d. Da Mc  bbacco use cont  yes 2 \( \text{No} \)  an  ssy  rraged?	tribute to t  3 Prot  Were autoprior to codeath?	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset Interval Betwe
as been signed by the attending physician and upper should be detached for use as the burial-transit	Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock, or heart failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ras a consequence of the same of pregnancy the 2 Fetal death with the same of death with th	200 S. HA  It enter the mode of dy  State of the second of	HELFENBE ARRISON S ring, such as cardia  Part Year.  Sease  alized  cy	23e. Did to	23d. Da Mo obacco use cont yes 2 No an syringed? 24b.	te of deliventh	Approximate Interval Between Onset and Death Williams Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset Interval Between I
as been signed by the attending physician and upper should be detached for use as the burial-transit	Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of o	a. Due to (o)  c. Due to (o)  d. 23c. If yes, outco 1   Live birt 4   Pregnar 9   Unknow	ras a consequence of the state	200 S. HA It enter the mode of dy  State A  Stat	HELFENBEARRISON S ing, such as cardia  PATYEN. Sease  Cy  Iven in Part I.	23e. Did to 1 \( \text{1} \) 24a. Was autop perfo	23d. Da Mc  23d. Da Mc  obacco use cont  yes 2 \( \sum \) No  an  ssy  rmed? 22d No	tribute to t	Approximate Interval Between Onset and Death August Succession of the Cause of death on the Cause of death on the Cause of death on the Cause of the
as been signed by the attending physician and up of the burial-transit at the burial-tra	To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock, or heart failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ras a consequence of as a consequence of a consequence	200 S. HA of enter the mode of dy	HELFENBEARRISON S ing, such as cardia  Latven  Sease  Ligan  cy  liven in Part I.  26. Place of De ther: 4 Nursing ury at ork?	23e. Did to 1 24a. Was autor perfo 1 Yes eath (Check only o	23d. Da Mc  23d. Da Mc  obacco use cont  yes 2 \( \sum \) No  an  ssy  rmed? 22d No	tribute to t	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Interval Between Onset In
In the this certificate has been signed by the attending physician and inference of the physi	To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock o	a. Due to (o)  b. Due to (o)  c. Due to (o)  d. Pregnar  g Unknow  The contributing to dea  Hospital: 1 Ing  g Jation  a. Due (o)  23c. If yes, outco  (Month, gation  oto be	ras a consequence of as a consequence of a consequence	200 S. HA of enter the mode of dy  State of th	HELFENBEARRISON S  Fing, such as cardia  Sease  Lisal  cy  liven in Part I.  26. Place of De  ther: 4 Nursing  ury at  ork?  Yes 2 No	23e. Did to 1 24a. Was autor perio 1 Yes eath (Check only o	23d. Da  Dacco use cont  Yes 2 No  an  Day  Trined?  24b.  Dan  Dence 6 Oth  Thom injury occur	te of deliveranth  tribute to t  3  Prot  Were autoprior to codeath?  1  Yes  per (Special red	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Interval Between Onset Interval Between Interval Between Interval Between Interval Between Interval Between Interval Between
After this certificate has been signed by the attending physician and injoin funeral director, page 2 should be detached for use as the burial-transit in a least transit in the state of t	To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock, or heart failure. Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ras a consequence of as a consequence of a consequence	200 S. HA of enter the mode of dy	HELFENBEARRISON S  Fing, such as cardia  Sease  Lisal  cy  liven in Part I.  26. Place of De  ther: 4 Nursing  ury at  ork?  Yes 2 No	23e. Did to 1 24a. Was autor perio 1 Yes eath (Check only o	23d. Da obacco use conf yes 2 No an 24b. sy rmed? 220 No dence 6 Oth now injury occur	te of deliveranth  tribute to t  3  Prot  Were autoprior to codeath?  1  Yes  per (Special red	Approximate Interval Between Onset and Death August Succession of Section 1982 August 1982
In the this certificate has been signed by the attending physician and inference of the physi	Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock o	complications that cauchly one cause on each a.  a.  Due to (o)  b.  Due to (o)  c.  Due to (o)  d.  23c. If yes, outcot   1   1   ing or other ined   28e. Place o building grants. To the best of the property of the position of the property of the proper	ras a consequence of as a consequence of pregnancy that at time of death with but not resulting in the but not resulting in the consequence of a consequence	200 S. HA of enter the mode of dy  State of th	HELFENBEARRISON S  ing, such as cardia  extrem  sease  cy  liven in Part I.  26. Place of De ther: 4 Nursing ury at ork?  Yes 2 No  stime, date and place	23e. Did to 1 1 Yes action (Scheck only of City or Townson) 28f. Location (Scheck only of City or Townson)	23d. Da  23d. Da  Mc  obacco use cont  Yes 2 \( \text{No} \)  an  Street and Numb  wn, State)  cause(s) and ma	tribute to t	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Interval Between Onset In
After this certificate has been signed by the attending physician and injoin funeral director, page 2 should be detached for use as the burial-transit in a least transit in the state of t	edical Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock o	a. Due to (or d. Due to (or d. Due to (or d. Due) one cause on each only one cause on each only one cause on each only one cause on each one d. Due to (or d. Due to (or d. Due) one cause one cause of the cause of	ras a consequence of as a consequence of petalogous and as a consequence of petalogous as a consequence of petalogous and as a consequence of petalogous and as a consequence of petalogous as a c	200 S. HA of enter the mode of dy  State of th	HELFENBEARRISON S  ing, such as cardia  extrem  sease  cy  liven in Part I.  26. Place of De ther: 4 Nursing ury at ork?  Yes 2 No  stime, date and place	23e. Did to 1 1 Yes action (Scheck only of City or Townson) 28f. Location (Scheck only of City or Townson)	23d. Da  23d. Da  Mc  obacco use cont  Yes 2 \( \text{No} \)  an  Street and Numb  wn, State)  cause(s) and ma	tribute to t	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset Interval Between
After this certificate has been signed by the attending physician and injoin funeral director, page 2 should be detached for use as the burial-transit in a least transit in the state of t	Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock, or heart failure. Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ras a consequence of as a consequence of petalogous and as a consequence of petalogous as a consequence of petalogous and as a consequence of petalogous as a conse	200 S. HA of enter the mode of dy  it was a second of the	HELFENBEARRISON S  ing, such as cardia  extrem  sease  cy  liven in Part I.  26. Place of De ther: 4 Nursing ury at ork?  Yes 2 No  stime, date and place	23e. Did to 1 24a. Was autor perfo 1 Yes eath (Check only of 28d. Describe for 28f. Location (Society or Townson) 28f. Lo	23d. Date signe	tribute to t   Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Interval Bet	
as been signed by the attending physician and a control of detached for use as the burial-transit at the control of the contro	edical Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of shock, or heart failure. List of the shock, or heart failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ras a consequence of plant of partient 2 EP/Outp. Injury Pary Injury At home, farring, etc. (Specify)	200 S. HA of enter the mode of dy  it will be th	HELFENBEARRISON S ing, such as cardia  Part I Sease  Ligar  Cy  Iven in Part I.  26. Place of Duther: 4 Nursing ury at ork?  Yes 2 No  solution, date and place opinion, death occurrence.	23e. Did to 1 24a. Was autor perfo 1 Yes eath (Check only of 28d. Describe for 28f. Location (Society or Townson) 28f. Lo	23d. Date signe	tribute to t	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Interval Bet
After this certificate has been signed by the attending physician and in property of the principle of the pr	edical Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock, or heart failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ras a consequence of plant of partient 2 EP/Outp. Injury Pary Injury At home, farring, etc. (Specify)	200 S. HA of enter the mode of dy  it will be th	HELFENBEARRISON S ing, such as cardia  Part I Sease  Ligar  Cy  Iven in Part I.  26. Place of Duther: 4 Nursing ury at ork?  Yes 2 No  solution, date and place opinion, death occurrence.	23e. Did to 1 24a. Was autor perfo 1 Yes eath (Check only of 28d. Describe for 28f. Location (Society or Townson) 28f. Lo	23d. Date signe	tribute to t   Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Interval Between Onset and Interval Between Onset Interval Between Onse	

			1 - For State Registrar	State of Maryla	and / Depa <i>Cel</i>	artment o rtificate	of Health a of Death	and Mental H	ygiene Reg. No	200	6 3	0044
	Physici /Medio		Decedent's Name (First, Middle, Last,     Edmund Lloyd Mi	llard				2. Date of D Month Augus	Da	y Yes	ar	ime of Death
	Examir	er	4a. Facility Name (If not institution, give Prince Georges Ho	spital		Chev			Pı	County of O		S
	Funeral Director		5. Social Security Number 577-32-1463 6. Security Securit	7. Age (In yr 1 M 2 F 78	s. last birthday) Yrs.	If Under 1 \ Months   D	ear If Under a Hours	Min. 8. Date of B (Month, L March	irth Day, Year) 28,	1928	Birthplace (S Country) Wash.	D • C •
	e Maryland	ctor	10a. State 10b. County D.C. N/A	_	City, Town or Lo							ide City Limits
	h with th	ai Dire	10e. Street and Number 4808 Ft. Totten Dr	ive, N.E.		10f. Zip Co	de 1-7510			tizen of What		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may injury or other treumatic event, it a Medical Examinative the modified at ODGE.	by Funeral Director		12. Was Decedent Ever in Armed Forces? 194 1★1Yes 2□No 1f Yes, Give Year or Dates:	6-	Was Decedent f Yes, specify	Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)		14. Race - A Black, W Specify: Africa	merican Indi hite, etc.	
21215-0036	within 72 hor ene. then "naturi the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed)  College (1-4or 5+) 5+	(Give	dent's Usual C kind of work o DO NOT use r	lone during most	of working		and of Busine		LICAN
Maryland 2	uld be filed Mental Hygid irked other itic event, the	To Be Co	17. Father's Name (First, Middle, Last) Oscar Millard		TTTI	страт		r's Name (First, Midd)		School		
Mary	od 2 sho Ith and t 27 is ma		19a. Informant's Name/Relationship (Ty. Jean H. Millard	pe, Print) (Wife)				r or Rural Route Num				
Baltimore,	Pages 1 ar		20a. Method of Disposition  1 🗷 Burial 2 Cremation 3 🗆 R  4 Donation 5 Other (Specify)	20b emoval from State	Place of Dispo cemetery, cren ck Cree	sition (Name of natory or other	of r place)	Date 9/7/06	20c. L	cation - City	or Town, Sta	ate
Balti	permit. Departmin imports eny inju		21. Signature of Funeral Service License		22	. Name and A	ddress of Facility	McGuire I	uner	al Ser	vice	20012
,	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the delecause of each line.  Sepsis  Oue to (or as a consi		er the mode of	dying, such as	cardiac or respiratory	arrest,		Interv	ximate al Between and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a none	squanee of):							
68760,	icate be executed physicien and the burial-transit	dical Exar	that initiated events resulting in death) Last	Multiple Due to (or as a conso Periphera	equence of):		sease					
P.O. Box 6	death certiff e attending od for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3□	Ectopic pregr Other (specif				23d. Date of o	delivery Day	Year
	The law requires that the de ste has been signed by the a page 2 should be detached t	ρ	Part II. Other significant conditions con Atrial Fibrillat		esulting in the ur	nderlying caus	e given in Part I.		tobacco i	use contribute		e of death?
Division of Vital Records,	hysicien: The faw re his certificete has be I director, page 2 sh	Completed	Congestive Heart	Failure				24a. Wha auto perd 1 □ Yes	s an opsy ormed? 20 No	prior t death	o completion	dings available n of cause of
Ť ŽİÇ	Physicien: r this certifice ral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 28 No	ospital: 1 XInpatient 2	☐ ER/Outpatien	R 3□ DOA	Othor	of Death <i>Ch</i> eck o <i>nly</i> sing Home 5 ☐ Res		6 □Other (S	pecify)	
ion o	ing P		27. Manner of Death  1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Describe				
DIVI	0 = 0 =	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	cify)				wn, State	o)		Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier   1 Certifying Phys (Check only one)   2 Medical Examir	ician: To the best of my killer: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the estigation, in	ne time, date and my opinion, deatl	I place, and due to the n occurred at the time	cause(s) , date and	and manner d place, and d	as stated. ue to the ca	use(s)
, ,	14 E	Σ	29b. Signature and title of certifier	anno		29c. Li	cense number	7	29d. Da	te signed (Mo	onth, Day, Ye	rar)
11	3 ( )		30. Name and address of person who co Ophnell Cumberba				venue, L	andover, M	ID 2	0785		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0.6 200	32 Registrar's Sig	nature Loc	di						

			1 - For Stete Registrer	State of Maryl	and / Depa <i>Cei</i>	artment of Hertificate of E	ealth and M Death		ne 2006	30045
	Physici /Medic		Decedent's Name (First, Middle, Last,     Thomas Ja	mes Murra	ау			2. Date of Death Month	Day Year	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give Memorial Hosp 5. Social Security Number 6. Sec. 215-20-0277	sital	yrs. last birthday) 81 Yrs.	4b. City, Town, or EaStor  If Under 1 Year  Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye 1uly 26,	ar) Co	h hplace (State or Foreign untry) ryland
			Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	ocation		ury 20, .	1923   Mai	10d. Inside City Limits
	ter death with the Marylan Items 23a or 28s-f ehow Instituted by recitified at	Director	MD Caroli  10e. Street and Number	ne	Prest	O II		10g.	Citizen of What Co	1 ☐ Yes 2 🙀 No untry?
	eath with	eral D	22403 Marsh Cr	eek Road	n II C 12 1	216			ited Sta	
9800	ours af	by Funeral	11. Marital Status  1 □ Never Married 2€ Married  3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 27☐ No	Specify:	Rican, etc.)	Black, White	
Maryland 21215-0036	within 72 hours ene. then "neturel" the Mudical Ex	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupation of work done do NOT use retired re Servi	uring most of workin	ng	reston	Irucking
nd 2	Hygi ther ther	Be Co	17. Father's Name (First, Middle, Last)					(First, Middle, Maie	den Sumame)	
ryla	Men	5	William C. M  19a. Informant's Name/Relationship (Ty	urray	19h Mailir	ng Address (Street ar	Bessie		huar Tourn State 7	in Code
, Ma	12 ha 7		Freda B. Murra	•		3 Marsh C				
Baltimore,	Pages nent of ant: If it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	lt. Pleas	natory`or other place sant Cemet	ery 09/07	7/06 P		Maryland
Bal	permit. Departr Imports eny inji		21. Signature of Funeral Service Licens	M. Pale	2 2	Name and Address 16 N. Maii	n St., Fe	mptom F deralsbur	uneral H g, MD 216	Home, P.A. 532
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the cause on each line.	death. Do not ento	er the mode of dying	, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a con	tia,	A/z heis	mes to	me_		yeurs
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence * r):					
68760,	ficate be executed physician and is the burial-transit	edical Ex	resulting in death) Last	Due to (or as a con	sequence of):					
.O. Box	the death certify the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \times \) Yes 2 \( \times \) No 9 \( \times \) Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ R 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
rds, P.	law requires that as been signed b 2 should be deta	ρ	Part II. Other significant conditions con			nderlying cause giver LSU				the cause of death?
of Vital Records,	The rate h page	Completed						24a. Was an autopsy performed 1 ☐ Yes 2 Ø	prior to death?	topsy findings available completion of cause of
<u> </u>	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	lospital:	2 ☐ ER/Outpatien	Other	26. Place of Death	1	e 6 □Other (Spec	of (c)
	Jing After fune		27. Manner of Death  1  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea.	28b. Time of	28c. Injury Works		8d. Describe how in		,,
Division	ital or Attenders safter death ai Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Ru late)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	ledicai	one)	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	vestigation, in my opi	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
)	with To Con	M	29b. Signature and title of certifier	Norte	ws	29c. License	4043	29d.	Date signed (Month	, Day, Year) 3, 2006
_			30. Same and address of person who co	NS. 119	S. Wesh	ngfor St	- Easton	5 cm,	21601	
9.	Sta Registr		31. Date filed (Monty, Pay, Year) 6 20	32. Registrar's Si		hade				

Murray, Thomas

			1 - For State Registrar	State of Maryland		artment of Hetificate of L			ene 20 (	)6	30046
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MARGARET ELIZA	ABETH MULFOR	D			2. Date of Death Month SEPTEM	Day Ye	ar	Time of Death 6:45 **
	Examir		4a. Fecility Name (If not institution, give s			4b. City, Town, or			4c. County of I		
	-		Chestertown Nur  5. Social Security Number 6. Sec			Cheste		8. Date of Birth	Kent	Distratana	(State or Foreign
	Funeral Director		213-44-2339	M 280 F 92	Yrs.	Months Days	Hours Min.	Nov 22	Year)	Country)	(State or Foreign
	land ow		Usual Residence of Decedent  10a, State 10b. County	10c. City,	Town or Lo	cation				10d. In	side City Limits
	B-feh	tor	MD Kent		Galer	ıa				12	Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?	
	eath w	eral	109 Cedarwood I	Dr.  12. Was Decedent Ever in U.S.	12.1	21635			U.S.A.		*
920	permit. Pages 1 end 2 should be filled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then *naturei', or items 23a or 28a-f show sty figury or other treumatic event, the Medical Examinar must be rotified at once.	by Funeral	11. Marital Status  1    Never Married 2   Married  3   Widowed 4   Divorced	Amed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	'	Vas Decedent of His f Yes, specify Cuban ☐ Yes 2 ☑ No	Specify:	Rican, etc.)		American Ind White, etc. Whi	
<u>ئ</u>	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation (completed)	16a. Deced	ent's Usual Occupat	tion uring most of work	kina 1	6b. Kind of Busin	ess/Industry	
12	within ane.	mpl	Efementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du OO NOT use retired)			United		
<u>q</u>	Hygid other	Be Co	17. Father's Name (First, Middle, Last)		Р	ostmaste		ne (First, Middle, M	Postal	Serv	ice
Maryland 21215-0036	uld be Mental rrked	To B	James W. Mulfo	ord			Annie	Thornle	Y		
la <sub>1</sub>	and l	1	19a. Informant's Name/Relationship (Ty)	1	19b. Maifin	g Address (Street ar	nd Number or Rui	ral Route Number,	City or Town, Sta	te, Zip Code	)
e) Z	1 end Health em 27 ther tu		Ann Symonds  20a. Method of Disposition	(niece)		Aaron Plation (Name of					
Baltimore,	ages ant of little if it		1 ☐ Burial 2 ☑ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	netery, crem	natory or other place	)		Oc. Location - City		tate
i E	mit. Poertme sortan / injur		21. Signatura of Puneral Service Lights		22	emation . Name and Address	of Facility	Still St. Bills	Smyrna,		
<u>m</u> —	Ped Fi	i d	170 C	M0051	$0  \begin{array}{c c} G \\ 1 \end{array}$	alena Fu 18 West	neral Cross	Home of St. Gal	Stephe ena, MI	n L.	Schaec 635
			23a. Part . Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death, e cause on each line.						Appr	oximate val Between
	Physician /Medical		Immediate Causé (Final disease or condition resulting in death)	Leukom						3	et and Death
7	Examiner			Due to (or as a consequer	nce of):						1
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nda-of):						
	te be executed ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for on a consequent							
8760,	sicien burial	aiE		Due to (or as a consequer	ice or):						
9	g phys	ledicai									
O. Box	The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	deliv <b>ery</b> Day	Year
<b>-</b>	ss that gned b	by Pr	Part II. Dther significant conditions con	ributing to death but not resulting	ng in the un	derlying cause giver	n in Part I.	23e. Did toba	icco use contribut	e to the cau	se of death?
ğ	w requires that been signed b should be deta	ted	HIZhelmer	5 ()1504	L Z L			1 🗌 Yes	2EN0 3	] Probably	4 Unknown
Il Hecords,		Completed						24a. Was an autopsy performed 1 Yes 2 (	prior deat	to completion	ndings available on of cause of
Vita	sician: certific irector,	Be	25. Was case referred to medical examiner?	ospital:				h (Check only one			
ō	g Phys er this eral di	n: To	1 Yes 2 No	1   Inpatient 2   ER	VOutpatient 3b. Time of	3 DOA Onler 28c. Injury a Work?	4 ☑ Nursing Ho	me 5 Residen		Specify)	
<u> </u>	Attending Physician: r death. ector: After this certific by the funeral director.	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		es 2 🗆 No				
DIVISION OF	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: At completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number of State)	Rural Rout	e Number,
	pspita hours unerei ly filled		29a. Certifier 1 Certifying Phys	cian: To the best of my knowle	dge, death	occurred at the time	, date and place,	and due to the cau	se(s) and manne	r as stated.	
	the H hin 24 the Fi	Aedicai	one) Medical Examin	er: On the basis of examination and manner stated.	and/or inv	estigation, in my opia	nion, death occur	red at the time, dat	e and place, and	due to the ca	
	Son To Fig.	Σ	29b. Signature and title of certifier	a la		29c. License		290	d. Date signed (M	/	(ear)
	,	-	30 Name and address of access the	notice of death (the or	Pa) (Fue - 5		2871		9116	10%	
9	2		<ol> <li>Name and address of person who cor</li> <li>Paul Donaher,</li> </ol>			th Main	St. Ga	alena. N	MD. 216	35	
	Sta		31. Date filed (Month, Day, Year)	32. Aegistrar's Signature	9					- <del>-</del>	
	Registra	ar	SEP 2 1 200	6 francis S.	A	end)					

			1 - State of M	laryland / Dep	ertificate of Death	Mental Hyg	iene 2006	30047
		- 1	Registrar  1. Decedent's Name (First, Middle, Last)		Timouto or Bourn	2. Date of Deat	h	3. Time of Death
	Physici		Patricia Jo NORD	YKF		Sep +	Day Year	9:50 PM
iki	/Medic Examin		4a. Facility Name (If not institution, give street and number	)	4b. City, Town, or Location of Deal		4c. County of Death	
			University of Maryland medica	il Systems	Boiltimore Cit	Y		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 S F 7. A	ge (In yrs. last birthda) 46 Yrs.	/) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Year) Cou	place (State or Foreign ntry)
	ט		Usual Residence of Decedent	40		Dec. 23	, 1999 10w	a
	uylan Ihow	_	10a. State 10b. County	10c. City, Town or L	Location			10d. Inside City Limits
	Ba-f a	cto	Maryland Frederick	Moni	ovia			1 ☐ Yes 2 ☒ No
	vith th	Director	10e. Street and Number		10f. Zip Code	11	0g. Citizen of What Cou	ntry?
	s 23s		12104 Ashcroft Terrace	Free in H.C. 12	21770	Sanafu Van as No	United S	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Was Deceden Armed Forces  1 □ Yes 2 ☑ II Yes, Give  1 □ Year or Dates	No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	Black, White,	
2	72 ho natur	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most of wo	rkina	16b. Kind of Business/Ir	ndustry
7	ithin ne.	Completed by	Elementary/Secondary (0-12) College (1-4or	life	DO NOT use retired)			
2	lled w tygier her ti	ပိ	17. Father's Name (First, Middle, Last)	Н.	omemaker	me (First, Middle, M	Own Ho	me
and	od of	Be					,	
Maryland	should Me mark	ို	Don M. Hayes  19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Number or R	M. McGowa ural Route Number.		code)
Σ	nd 2 state at trau		Wayne D. Nordyke / Husban	d 1210	4 Ashcroft Terrace	e Monrov	ia. Marvlan	d 21770
e,	s 1 a f Hea item othe		20a. Method of Disposition	20b. Place of Disp	position (Name of	Date :	20c. Location - City or T	
Ē	Page nent c int: If iry or		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify)	9	· · · · · Sep	tember 2006	Frederick,	Marvland
Baltimore,	permit. Departn Imports any inju		21. Signature of Liner I Service Licensee	100	22. Name and Address of Facility C E. Ridgeville bl	Stauffer	Funeral Hom Airy, Maryl	es, P.A.
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not en				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition	. 0	ratory Distress	Syndro	me	Onset and Death
	Examiner		Flan		load / Renal 1	Failure	,	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s a consequence of):	10000	0-1100		
	icuted nd rransi	Examiner	Cause (Disease or injury that initiated events c C.	1 Stage	iver Disease			
90,	cate be executed physicien and the burial-transit	EX	resulting in death) Last Due to (or a	s a consequence of):				
8760,	cate b	dicat	d					
9 X	ding p	/Me	IF FEMALE: 23c. If yes, outcom	e of pregnancy			22d Date of deli-	-
Bo	ires thet the death certific signed by the attending f d be detached for use as	by Physician/Me	in the past 12 months?	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
o.	the d by the ached	hysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown 9 ☐ Unknown					
Œ.	s thet gned b	y P	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	the cause of death?
ğ	w require been sign should b		Alcoholism			1 ☐ Ye	es 2 1 No 3 Pro	bably 4 Unknown
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires thet the death certifi within 24 hours effer death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed				24a. Was an autops perform	y prior to co	opsy findings available ompletion of cause of
/ita	clan: ertific ector,	Be	25. Was case referred to medical examiner?			ath (Check only on	θ)	
<del>o</del>	Physi this c	L 2	1 Yes 2 Hospital: 1 Hospital: 27. Manner of Death 28a. Date of In				ence 6 Other (Speci	fy)
u	ding I	lon	1 ☐ Hatural 5 ☐ Pending (Month, D			28d. Describe no	w injury occurred	
isi	deat deat ctor; y the	fica	3 Suicide 6 Could not be 28e. Place of li	njury - At home, farm, s		28f. Location (St.	reet and Number or Run	al Route Number.
ă	el or /	Certification:	4 Homicide determined building, 6	etc. (Specify)	7.53	City or Town	n, State)	
	To the Hospital or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1 Certifying Physicism To the besis and manner and manner of the besis and manner of the besis and manner of the besis and manner of the besis and manner of the besis and manner of the besis and manner of the besis and manner of the besis and manner of the besis and manner of the besis and manner of the besis and the	of examination and/or i	of the time, data and place oversignation, in my opinion, death occurred	and due to the ca urred at the time, da	tuce(s) and manner as s ate and place, and due t	valed. o the cause(s)
	ro the Mithin Fo the	Me	29b. Signature and title of certifier		29c. License number	29	9d. Date signed (Month,	Day, Year)
	_		NIARASH ZARBA	LIAN	- AU4176435	216715 3	Sept 02.	2006
	Ŕ		30. Name and address of person who completed cause of $3 + 5 = 5 = 5 = 5$		a, Print)		,	
, de	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6 2006 32. Figis	trar's Signature	porte			

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Anson C. Nesbitt

2006 30048

		1- For State Registrar		Certifi	cate of	Death			R	teg. No.	21	JU	0 31	J U 4
Physic	ian/	1. Decedent's Name (First, Midd	le,Last)						Date of Dea Month		Vaar	3	3. Time of Deat	ih
Medical Exam	iiner	Anson	Carter	Nesbitt				1	August 31	Day 1, 2006	Year		0226 hrs	
		4a. Facility Name (if not institution	n, give street and n		4	b. City, Town, or L	ocation of	f Death		4c. C	County of	Death		
		University Hospital				Baltimore				[	Non	٩		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	oirthday)	If Under 1 Year	If Under	24Hrs. 8	B. Date of Bi	rth(MM/DE			place (State or	
Director		016 00 0501	1 TZ 1. 0 F	1.6		Months Days		Min.		` .		Foreign	· ,	
		216-29-8521	1 X M 2 F	16	Yrs.			<u> </u>	June 1	17, 1	990	Cour	<sup>ntry)</sup> Mary	land
ž.		Usual Residence of Decedent  10a. State 10b. County		10c, City, Toy								- 1	IOd. Inside City	13-01
w any		Toa. State		Toc. City, Tov	vii oi Locatio	on						- 1		
and sho	b	Maryland Fred	erick	N	lount .	Airy							1 Yes 2	X No
Aaryland 28a-f show 1 at once.	ect.	10e Street and Number				10f. Zip Code			1	l0g Citize	n of Wha	t Countr	y?	
th the Maryland 23a or 28a-f she notified at once	Director	8519 Woodville	Road			217	71			II	nita	d C+	ates	
s 238	曺	11. Marital Status		cedent Ever in U.S.	13. Was	Decedent of Hisp	·_	in? (Speci	fv Yes or No				an Indian, Black	k.
ath vitem	Funeral	1 X Never Married 2 M	arried Armed F		If Ye	s, specify Cuban,	Mexican,	Puerto Ric	can, etc.)		White,		,	,
er de	교	3 Widowed 4 Div	orced If Yes, Give Ye	2 X No		Yes 2 X No	Enocific				nontie:	T.TL - 2 A		
hours after 'natural'', Examiner	þ	15. Decedent's Education (Spe	or Dates:			s Usual Decupation		ind of work	, dono		pecify:			
hou hat	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		st of working life.				TOD. KIII	id of Busi	11622/1110	ausiry	
D36 thin 72 ne. • than "	l e		College (	1-4 (1 5+)	α.	1								ŀ
with jene to	l E	10			St	udent				1		gh S	School	
Hyge Hyge		17. Father's Name (First, Middle,				1		,	rst, Middle,		,			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Peter Shane No							e Lyni					
AD 21215-003 2 should be filed within 1 and Mental Hygiene. 27 is marked other thin matic event, the Medi	은	19a Informant's Name/Relations	hip (Type, Print)			Address (Street								
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Peter S. Nesbi	tt / Fath		8519	Woodvill	e Roa	ad M	t. Aiı	ry, M	ary1	and	21771	
Baltimore, MD 2  Descript Pages I and 2 shoul Department of Health and M Important: If litem 27 is an njury or other traumatic.		20a. Method of Disposition			e of Disposit natory or other	ion (Name of cem	etery,	_	ate		cation - C	ity or To	own, State	
Pages hent of lant: If or other		1 Burial 2 X Cremation		On State	•	• •		Sept	ember	E 1		1_ 3	1	,
Itin it P rtme ortan y or		4 Donation 5 Other State 21 Signature of Funeral Service		,  Frede		Cremator  ame and Address		Ο,	2006	pred	eric	K, 1	Marylan	.a
Baltimore, MI permit Pages   and 2 a Department of Health a Important: If item 27 injury or other traum		21 digital de divi diferal del de	1				- 11 a	Stau	iler .	runer	al H	omes	s, P.A.	771
	- /	23a, Part I. Enter the disease, or	comotion that	courself the death Do		. Ridgev								
Physician /Medical		fajlure. List only one cause	on each line.	auseoure death. Do	not enter the	e mode or dying, s	oudii as ca	ilulac or re	spiratory ari	est, shock	t, or near		Approximate In Between Ons	set and
Examiner		Imm diate Cause (Final disease	a. Head Injur	ies									Death	
		or condition resulting in death)	Due to (or as	a consequence of):										
	_	Sequentially list conditions,	b									_		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		a consequence of):										
	릚	(Disease or injury that initiated events resulting in death) Last	C	a consequence of):		_					_	_		
ited 1 ansit	Шă	events resulting in death) Last	d.											
8760, rificate be executed ng physician and as the burial - transit	ın/Medical	UNPENDED	AMENDED											-
O, e be e sicia buria	ed													
8760, tificate being physic as the bur	<u>Ş</u>	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregnant	_	aldeath 3	Fatania				Date of de			
68 certif	<u>ë</u>	past 12 months?		nant at time of death			Ectopic	pregnancy	,	IV	lonth	Da	y <b>Y</b> ea	ar
Box e death c the atten	ys.	1 Yes 2 No 9 Uni	known 9 Unkn		□ Oth	er (Specify)								1
P.O. Box 61 s that the death cert med by the attendir e detached for use a	Physicia	Part II. Other significant condit	ions contributing t	o death but not result	tina in the un	nderlying cause gr	ven in Par	† [	23e. Did to	obacco us	e contribu	ite to the	e cause of dea	th?
P.O. es that the igned by be detach	þ		J		Ü	, 5			_	_			bly 4 Unk	
S, P puires t an sign lid be c	1 73							_ ;		235	/			
ords w requir	i je								24a. Was autor				psy findings av	
ecc ne lar te ha	ΙĒ								perfo	rmed? 2 No	_	ath?	2 —	No
tal Recision: The certificate ector, page		25. Was case referred to medica	1 1	<del></del>		26 Place	of Death (	Check only		2140		/ Yes		-
Division of Vital Records, tal or Attending Physician: The law requirer as after death. al Director: After this certificate has been siled in by the fineral director, page 2 should be led in by the fineral director, page 2 should be	Be	examiner?		Inpatient 2 ER	Outpatient		Whor:	Nursing H		Residenc		Other:		
f Vi Physi er this ral dir		1 ✓ Yes 2 No 27. Manner of Death	28a. Date		o. Time of In	o box			d. Describe		-			
n of ding Ph After t	;;	1 Natural	Aug Monti	h. Dav.Year)	30 hrs	·   _ · ·	es 2 🗸	lDri	iver of AT				n	
siOr ttend death ctor:	j <del>a</del>	Penc	stigation				es Z	NO						
or A Or A Dire	≝		a not be	ce of Injury - At home.	, farm, street	, factory, office bu	iilding, etc	. 281	f. Location ( or Town, §		Number	or Rura	I Route Numbe	r, City
Divis pital or At ours after d eral Direc filled in by	Certification:	4 Homicide dete	rmined (Specify)	Unpaved Roa	d			85	20 Wood	sville R	oad, M	ount A	Airy, MD	
Divisior Hospital or Attene 24 hours after death Funeral Director: stely filled in by the		29a. Certifier (Check only) Certifying Pl	hysician: To the be	st of my knowledge, o	death occurre	ed at the time, dat	e and plac	ce, and due	e to the caus	se(s) and r	manner a	s started	d.	
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical	one) 2 Medical Exa	miner: On the basis	of examination and/o	r investigatio	on, in my opinion,	death occ	urred at the	e time, date	and place	, and due	to the	cause(s)	
M. IN	and manner stated  29c. License number  29d. Date signed (Month, Day, Year)													
		()	11/	1-		O.C.N	1.E.			Sente	mber 2	2006	6	
			NUL									,	-	
13		30. Name and address of person				Checat Dall	ma== *	AD 0400	14					
1-		·		cal Examiner		ı Sireet, Baltı	more, N	/ID 2120	/ I					
	State	31. Date filed (Month, Day, Year)	6 2006 32. R	istrar's Signature	4	l and								

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

Newell, Rober

2006

State of Maryland / Department of Health and Mental Hygiene 200630050 State
Registrar AMEND#18perFH9/13/06, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year **Physician** ZOLMA Month NATHANSON 2:05P SEPT. 1, /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner POTOMAC VALLEY NURSING HOME MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2∰F Months Hours 577-18-8695 88 Yrs Director MARCH 11, 1918 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show rthen "neturel", or iteme 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND MONTGOMERY CHEVY CHASE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2701 SPENCER ROAD 20815 UNITED STATES OF AMERICA Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UNITED STATES GOVERNMENT SECRETARY 12 permit. Pages 1 and 2 should be filed w
Dependent of Health and Mental Hygier
Important: If Itam 27 is marked other til
eny Injury or other traumatic event, III
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) DAVID NATHANSON MARTHA -ALTSE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE ZEVIN - SISTER 2701 SPENCER ROAD, CHEVY CHASE, MD 20815 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State KING DAVID MEMORIAL GARDEN 09/04/06 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Ligenses 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit FAILURE TO THRIVE Due to (or as a consequence of) Box 68760, physicien DEMENTIA Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury after death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funarel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -csocy Doc 62435 40 CL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAYED ELSAYYAD 9715 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar 06 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Fleath and Memar Hygiene

2	n	0	6	3	N	0	5	
Seem	$\mathbf{\circ}$	·~	$\sim$	0	$\mathbf{v}$	$\sim$	•	

		Registrar Certificate of Death		Reg. No.	200	0 3003
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) Santos Amilcar Munoz Nieto		eath Day ber 3, 2(	Year	3. Time of Death 0734 hrs
g garantina		4a. Facility Name (if not institution, give street and number)  1417 Kahawha Street #301  4b. City, Town, or Location of Hyattsville	of Death		County of Death rince George	's
Funeral				Birth (MM/E	D/YYYY) 9. Birtl Foreign	nplace (State or
Director		219-31-1452   1XM 2 F   46 Yrs.   Months   Days   Hours	Min. 11/2	7/195	9 Cou	<sup>ntry</sup> Salvador
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
<b>à</b> .		Maryland Prince George's Hyattsville				1 X Yes 2 No
te Maryland or 28a-f show fied at once.	cto	10e. Street and Number 10f. Zip Code	<del></del>	10g. Citiz	en of What Coun	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Director	1417 Kanawha Street #301 20783		-	alvador	.,,
th with ems 2.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig 1 Never Married 2 Married Armed Forces? 15. Was Decedent of Hispanic Orig 16. Yes, specify Cuban, Mexican,		No- 1	14. Race - Americ White, etc.	an Indian, Black,
er dea	Fur	1 Voc 2 V No	Salvadora	n .	Specify: Whit	:e
urs afi tural' amine	d by	15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give k	ind of work done		nd of Business/In	
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT	use retired)	Cor	man	
5-0036 led within 72 Hygiene. other than the Medical	duc	10th Carpenter			structio	on
21215-0036 suld be filed within 7 Mental Hygiene marked other than	Be C	17. Father's Name (First, Middle, Last)  Humberto Nieto  Mari	s Name (Eirst, Middle Julia a <del>Judia</del> M	e, Maiden S	Surname)	
imore, MD 2121; Pages I and 2 should be fil ment of Health and Mental I tant: If iten 27 is marked or other traumatic event. I	To E	19a. Informant's Name/Relationship (Type, Print )  19b. Mailting Address (Street and Num 1417 Kanawha Stre				Zip Code)
MD 1d 2 sho thth and m 27 is aumati		Idalia D. Arguera/wife Hyattsville, Mary	1and, 207	83		
ore, MC es l and 2 s of Health au If item 27		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or T an Migue	
im C Page ment c		4 Donation 5 Other Specify: Family Cemetery	09-11-200	6 E	1 Salvad	lor
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility				
Physician		23a. Part I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as ca				Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Cardiomegaly				Between Onset and Death
Çxaminer		or condition resulting in death)  Due to (or as a consequence of):				
	Ŀ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C.				
uted d ansit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.				
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	an/Medical	UNPENDED AMENDED				
68760, ertificate be ding physici e as the buri	/Me	F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d.	Date of delivery	
certife to certife to certife use as	cian	2250. Was becorder pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy	V	Month Da	y Year
Box e death of the atter	Physicia	1 Yes 2 No 9 Unknown 9 Unknown		-27		1
ords, P.O. Box 68.  w requires that the death certifi s been signed by the attending	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par				e cause of death?
S, F quires en sign	ted		1,000			bly 4 Unknown
Orc law re has be	Completed			opsy formed?		ppsy findings available impletion of cause of
tal Records cian: The law requi certificate has been ector, page 2 should	S		1 🗸 Yes		1 🗸 Yes	2 No
Vital I ysician: his certifi director,	Be	25. Was case referred to medical examiner?  Hospital. 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 DOA Other 2 DOA OTHER 2 DOA OTHER 2 DOA DOA DOA DOA DOA DOA DOA DOA DOA DOA	Check only one)  Nursing Home 5	Posidon	ce 6 🗸 Other:	
of Viring Physical After this funeral dir	٦.	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work?				3Cerie
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	Certification	1 V Natural 5 Pending 2 Accident Investigation (Molitin, Day, Year)  1 Yes 2	No			
NISI or Att after d Direct	tifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc	. 28f. Location or Town		d Number or Rura	Route Number, City
Divi	Cer	4 Homicide determined (Specify)  29a. Certifier Operation Tables				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	check only  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (check only  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ				
To To Com	Med	and manner stated.  29b. Agnature and title of certifier 29c. License number		_	ate signed (Mont	
(3)		Markette Von Yorks O.C.M.E.			ember 4, 200	
		30. Name and address of person who completed cause of death (Item 23a)				
CIL		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201			
St Regis	ate trar	31. Date filed (Month, Day, Year) SEP 9 8 2006				

		1 - For State Registrar		Marylar	nd / Depa <i>Cei</i>	artment o	f Health of Death	and M		Reg. No.	006	30052
Physic /Med	lical	Decedent's Name (First, Middent)     H. William  4a. Facility Name (If not institution)	Overholt	pher)		4b. City, Tow	n or Location	of Doath	2. Date of De Month Augus	Day t 29,	Year 2006 nty of Death	3. Time of Death 8:40PM M
Exam	iner	1704 Crestwo		iber)		Salis		1 Of Death			omico	
Funera Directo		5. Social Security Number  220-10-6980	6. Sex. 1 M 2 □ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 You Months Da	ar If Unde	or 24 Hrs. Min.	8. Date of Bir (Month, Da 06-09-	th y, Year) 1919	9. Birthpl Count Ohio	ace (State or Foreign try)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other traumatic event, the Medical Evertinal Institute at one.	To Be Completed by Funeral Director	(Specify only high Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle Howard S. Ove: 19a. Informant's Name/Relation Phyllis Jones 20a. Method of Disposition 18 Burial 2 Cremation 4 Donation 5 Other (2) Signature of Fun-ral Service 23a. Parl 1. Enter the disease, (2)	Dad  12. Was Decermed Armed For 1   Yes   Yes   Given For Dank's Education   Style of College (1-none)   Col	dent Ever in Uces? essential 20b. Factor 5+)  State Qu  M00295	16a. Deceding (Give (Give (Far 19b. Mailir 1704))  Place of Disponementary, creminton	Vas Decedent Yes, specify (1 Yes 2 American Vasual Oct kind of work of the Crestwo Steel (1 Yes 1 Yes 2 American Varies of the Crestwo Steel (1 Yes 1 Yes 2 American Varies of the Crestwo Steel (1 Yes 1 Ye	1 of Hispanic Cuban, Mexico Cuban, Mexico Cupation me during modulired)  18. Moti Mar eet and Numicod Drii place)  y dress of Faci neral erset	ther's Name  Ty G.  ber or Rura  LVe, S  09/03  dility  Home  Ave.	(First, Middle, Cather: Route Number alisburate /2006	14. F Spe 16b. Kind of Da: Maiden Sum S sr, City or Tow ry, MD 20c. Locatio Pocomo	of What Counts A lace - America lack, White, e city: Whit Business/Ind iry ame) 21804 n - City or Too oke Cit	an Indian, stc.  Ce ustry  Code)  wn, State  Cy, MD  21853  Approximate
death certificate be executed  A second of the second of t	Ical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consequence or a consequence or a consequence or a consequence or a consequenc	uence of):	52	riseo	r se	,			Interval Between Onset and Death
death certifi e attending   d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2☐Fete ant at time of d	ldeath 3□	Ectopic pregna Other (specify					Date of deliver Month I	y Day Year
The law requires that the are has been signed by the page 2 should be detached.	b	Part II. Other significant condit	te			nderlying cause	given in Part	: l.		es 2. No	3 🗌 Proba	e cause of death?
hysician: The law nis certificate has b I director, page 2 st	Completed	25. Was case referred to medic		eno.	no	J			1 ☐ Yes	2 No	death?	sy findings available pletion of cause of
ding Pl h. After ti funera	Certification; To Be	examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pend	Hospital: 1  In In 28a. Date or (Month)	f Injury n, Day Year)	ER/Outpatien 28b. Time of Injury	28c. I	Other: 4 N njury at Vork? Nork? 2	Nursing Hon	(Check only one 5 Residence 8d. Describe h	dence 6 20 now injury occ	urred	rs Residen
To the Hospital or Attan within 24 hours after deat To tha Funeral Diractor: completely filled in by the		4 Homicide deter	ng Physician: To the I	g, etc. (Specification of the state of my known in a state of my known in a state of examina in a state of exa	y)  wledge, death	eet, factory, offi	e time, date a	and place, a	City or Tow	n, State) cause(s) and	manner as sta	Route Number,  sted. the cause(s)
omplet	Medical	one) 29b. Signature and title of certific	and mann	er stated.		29c. Lic	ense number			29d. Date sign	ned (Month, D	ay, Year)
⊢ s ⊢ ō	Y	) (	Ham			D25	219			08-30-	-06	
		30. Name and address of person Charles Stegma	ın M.D., Mt	Verno	n Road	'	ess An	ne, M	D 21853			
Si Regis	tate trar	31. Date filed (Month, Day, Yea.	5 2006 b	gistar's Signa	iture	Level	1					

			- I loade	State of Maryland / I	Dena	rtment of b	lealth and N	ll Copies Ai lental Hygie	ne o o	e.	
			1 - State Registrar	otato ot marytana,	Cen	tificate of	Death	Reg.	No. 201	16	30053
	Dhysia	ion	1. Decedent's Name (First, Middle, Las		2			2. Date of Death		ear	3. Time of Death
	Physic /Medi		L-LIZABO		301	2NC		August		006	5:06 a <sup>M</sup>
1	Exami	ner	4a. Facility Name (If not institution, give				r Location of Death		4c. County of		. 1
	Euporal		480 Ixworth Cour 5. Social Security Number 6. Se		rthdav)	Sever	na Park	8. Date of Birth	Anne A		
Н	Funeral Director			□M 2⊠F 71	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	1935 T		ce (State or Foreign ) ngton, D. C
	pud *		Usual Residence of Decedent  10a, State 10b, County	10c. City, Tow	m or l or	ation					
	f eho	ō	MD Anne Ar			Park				100.	. Inside City Limits 1 ☐ Yes 2 ☑ No
	72 hours atter death with the Maryland naturel', or items 23a or 28a-1 ehow dical Exactinat must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of Wha	at Country	?
	th with	a D	600 McKinsey Park	Drive Unit	201	2	21146		τ	JSA	
	tems	uner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black	American White, etc	Indian,
36	rs atte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1  Yes 2  No If Yes, Give Year or Dates:	1	□Yes 2½ No	Specify:		Specify:		
Maryland 21215-0036	2 hou	ted	15. Decedent's Edu	ication 16a	. Decede	ent's Usual Occup	ation	166	. Kind of Busin	ess/Indus	stry
218	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	,	ing St	t. John	the	Évangelist
21	led wi	Con		2 Tea	achei	r/Admini		Assistant		hool	
anc	d be ti	Be	17. Father's Name (First, Middle, Last)  Jack Gaffney					e (First, Middle, Maid e Shannon			
ž	shoule nd Me mark imatic	은	19a. Informant's Name/Relationship (T	rpe, Print) 19b	. Mailing	Address (Street		al Route Number, Ci		ite Zin Co	nde)
	alth al		James Edward Osbor				Park Dr.				MD 21146
ore	of He of He fitem roth		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ F	20b. Place o		ition (Name of atory or other place		Date 200	. Location - Cit		
Baltimore,	ment tant: I		4 □Donation 5 □ Other (Specify)	Metro	cre	ematory	20		Baltimo	re, N	<b>√</b> ID
Bal	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!, or items 23s or 28s-1 show any Injury or other traumatic event, the Madical Examinating must be notified at once.		21. Signature of Faperral Service Lidence	9 Mu-	Ba 49	Name and Addre	s of Facility Sons, P.	A. Sever	na Parl	ç Fun	eral Home 21146
	Physician /Medical Examiner	16	23a. ParM. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Dome vital caused the death. Do ne cause on each line.  Due to (or as a consequence or Due	of):			or respiratory arrest,		Int	pproximate terval Between nset and Death
68760,	icate be executed physicien and s the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
P.O. Box (	The law requires that the death certitica ate has been signed by the attending ph bage 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≥ Uyo 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Da	y Year
Ū.	s that med b e deta	Y P	Part II. Other significant conditions co	ntributing to death but not resulting in	n the und	derlying cause give	en in Part I.	23e. Did tobaco	o use contribu	te to the c	ause of death?
ğ	w requires to been signer should be	ed	Seizure Di	SORPER				1 ☐ Yes	2 5 30	] Probabl	y 4 ∐Unknown
Records,	The law rate has be rage 2 sh	Completed by	HYPERTENS	ion				24a. Was an autopsy performed	? prior	r to comple th?	findings available etion of cause of
Vita	icien: Th certiticate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 Yes 2 Check only one	NO IL	Yes 2	I NO
<u></u>	hysic this ce al dire	ဥ	1 □ Yes 2 Ono	lospital: 1 ☐ Inpatient 2 ☐ ER/Ou		3□ DOA Oth	er: 4 ☐ Nursing Ho	me 5 ☐ Residence	6 <b>⊠</b> Other (	Specify)	esidence
Division of	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death  1	(Month, Day Year)	Time of njury		<br Yes 2 □ No	28d. Describe how in			
<u>&gt;</u>	ital or Attender is after death al Director: led in by the	Certif	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stree	et, factory, office		28f. Location (Street City or Town, St		r Rurai Ro	oute Number,
	To the Hospitai or A within 24 hours after To the Funeral Directompletely tilled in by	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	dor inve	occurred at the time estigation, in my op	ne, date and place, a pinion, death occurr	and due to the cause ed at the time, date a	e(s) and manne and place, and	r as stated	d. e cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	111. 1000		29c. License		29d. l	Date signed (N	lonth, Day	r, Year)
)			1 minds	Typerson		Ve	t6360	A	iguit	24:	2006
	11		30. Name and ado ess of person who co	impleted cause of death (Item 23a) (	(Type, Pi	rint)	1000 -11.	August Ri	1	-0.	I AL
	4 Sta	to	31. Date filed (Month, Day, Year)	32. 3 vistrar's Signature	Y 60	or vete	MS/16	isway Ri	Ille 12	SULL	e, mi
	Registr			nne de la constitution de la con	A						

State of Maryland / Department of Health and Mental Hygiene 2006 30054 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Irene Ruth Orkin August 31, 2006 2006 Physician 9:22 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville The Casey House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 10, 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F Vrs 1930 Maryland 579-34-4763 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 No Directo MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 20906 3100 N. Leisure World Blvd. #312 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 21∑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ntal Hygiene. ed other than " avant, the Me Elementary/Secondary (0-12) College (1-4or 5+) Surgeon General Research Secretary 12 permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: if item 27 is marked oth any injurg of other traumatic avant onca. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Kramer David Leach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20906 3100 N. Leisure World Blvd. #312 Silver Spring, MD 19a. Informant's Name/Relationship (Type, Print) Leonard Orkin- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Bemoval from State Other (Specify) King David Memorial 9-5-06 Falls Church, VA 21. Signa ve of Furer I Service Licensee 22. Danmansky Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificete 2X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 10 Other (Specify Hospice 1 ☐ Yes 2 ☒ No Certification; To instant Director: After the 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0058032 Milliams DO 4 9-1-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 Cynthia M. Williams, DO Montgomery Hospice 6001 Muncaster Mill Rd. Rockville, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2006

Registrar

SEP

		1	For State Registrar	Sta	ate of	Marylan		artmen <i>rtificat</i>			ind Me		giene Reg. No.	2006	5 3	005	55
			Decedent's Name (First, Middle	, Last)			-					2. Date of De		Year		ime of Deat	1
	Physicia	_	Charles Gordon	n Dri	tcha	ard						Septe	•		6 1	0:00 <sup>a</sup>	М
	/Medic Examin	_	4a. Facility Name (If not institution					4b. City,	Town, or	Location o	f Death		4c. (	County of Dea			
			10612 Margate	Road						Spr					tgome		
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2		7. Age (In yrs.		If Under Months		If Under a	24 Hrs. Min.	<ol> <li>Date of Bi (Month, D)</li> </ol>	ay, Year)	C	thplace (Sountry)	State or Fore	eign
	Director		521-28-7242			8:	3 Yrs.					Aug.	20, 1	923 C	olora	ado	
-	20	-	Usual Residence of Decedent  10a, State 10b, County			10c. Ci	ty, Town or L	ocation							10d. In:	side City Lin	nits
	anyle ehov	2	Tod. State												10	]Yes 2☐	NO
	78 N N N N N N N N N N N N N N N N N N N	ect	Maryland Monto	jomery			Silver	Spri 10f. Zij					10g. Citiz	en of What C	ountry?		
13	with	늅		. D						20901				USA			
:	death with the Marylend ms 23s or 28s-f show	Funeral Director	10612 Margate	12. W	as Dece	edent Ever in U	J.S. 13.	Was Dece			gin? (Spe	cify Yes or N Rican, etc.)	0 1	4. Race - Am	erican Inc	lian,	
	ter d	딆	1 Never Married 2 Marr		med For ₩Yes Yes, Giv	2 No					i, Puerto F	tican, etc.)		Black, Whi			
ָבָר בּיינים מילים	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	lf Y	Yes, Giv ear or Da		-51 & Kor	1☐Yes ea	214 No	Ѕресіту:				Speakhit.	e		
2-003e	filed within 72 hours after death with the Maryler Hygiene. Hygiene, then hard natural, or Items 23s or 28s-f ehow ther then hard Examiner must be notified at ent, the Madical Examiner must be notified at	Completed	15. Deceden (Specify only highes	t's Education	n inleted)		16a. Dece	edent's Usu	rk done d	turina mosi	t of workin	ig .	16b. Kir	nd of Business	s/Industry		
2	B. B. T. Mad	ple	Elementary/Secondary (0-12)		ollege (1	-4or 5+)	life.	DO NOT	se retired	)		•		Feder	al G	averni	ment
7	filed within the Hygiene.  other then tent.	5			5+			Rese	arcn	Anal		(First, Middle			<u> </u>	J V C I I II	
		Be	17. Father's Name (First, Middle, Charles Gordon		char	d Sr				18. Mothe		evieve		_			
<u>8</u>	should be and Mental I amarked o	ဥ				.u, 51.	1		(2)	- 146 5				Town, State,	Zin Codo	1	
Maryland	2 sh and le m		19a. Informant's Name/Relations					-						MD 20		,	1
<u>ح</u>	and fealth im 27		Deane Shure/ A	ttorne	<u>:</u> У	20b.	Place of Disp			5 001		ate		cation - City o		tate	_
altımore,	T of T	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		val from	State	cemetery, creetropoli	ematory or	other plac		-	mber 7	7	ndria,Vi			- 1
	tmen tent:		4 Donation 5 Other (S		_	110	-		_			06					-
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny Injury or other treumatic evones.		21. Signature of Funeral Service	Oca	مو	<b></b>	5	00 Un	iver	sity	Blvd	, W, S	ilver	e Inc.	g, M		01
			23a. Part1. Enter the disease, or shock, of heart failure. List	complicatio	ns that c	aused the dea	th. Do not e	nter the mo	de of dyin	g, such as	cardiac o	r respiratory	arrest,		Inter	oximate val Betweer et and Deatl	
	Physician		Immediate Cause (Final disease or condition			ary Art	erv Di	sease	:						1 Y		"
Ĩ	/Medical		resulting in death)	a. 00		(or as a conse											
	Examiner		Sequentially list conditions,	<sub>b.</sub> Hy	pert	ension									2 Y	ears	
	D ==	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Dua to	(ਪਾ ਬਤ ਕ ਰਹਮਤਰ	quanta of).										
	acuter nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	<sub>c.</sub> Ca		omyo at									-		
760,	be executed sicien and burial-transit		resulting in deathly cast		Due to	(or as a conse	quence oi):										
376	ate be ex hysicien the burial	licai		d.	_					_					1		
<u>.</u>	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	220 1	fune out	tcome of pregr	nancy							23d. Date of d	alivan		
80	ath o	lan/	23b. Was decedent pregnant in the past 12 months?	1	1 Live t	ointh 2 ☐ Fet nant at time of	tel death 3	□Ectopic		,				Month	Day	Year	Ŷ
.O. Box	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkn		dealii 3	□ Other (s	pecity)								
<u>.</u>	res that the de signed by the a be detached t		Part II. Other significant conditi	ons contribu	uting to d	leath but not re	sulting in the	underlying	cause giv	en in Part	l.	23e. Dio	i tobacco u	ise contribute	to the car	use of death	1?
ŝ	signe signe	1 by	Paroxysmal Atr		-							10	Yes 2	ŠNo 3□	Probably	4 □Unkr	nown
Records,	w require been si should I	Completed	_Paroxysmal_Atr 	ldi f.	LI) E-II-	LLativi						24a, Wa	ıs an	24b. Were	autopsy fi	ndinos avai	lable
Sec.	hes hes by	ig E										aut per	opsy formed?	prior to death	o complet	ion of cause	e of
E	r: Th												2 🛂 No	1 U Y	es 2	No	
<u>#</u>	ding Physician: The h.h. h. After this certificate h. funeral director, page	Be	25. Was case referred to medica examiner?	Hosp	ital:	1	750/0:45-44	200	Oth			(Check only		6 ∐Other (Sp	accifu)		
ō	Phys this ral di	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	2	8a. Date	Inpatient 2	28b. Time		28c. Injur Wor	4111		28d. Describ			Journ J		
on O	ding h. After fune	ig.	1 X Natural 5 ☐ Pendi		(Mon	nth, Day Year)	Injun	M		rk? Yes 2.⊑	]No						
S	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could	loot bo	8e. Place	e of Injury - At	home, farm,	street, facto	ry, office			28f. Location	(Street ar	d Number or	Rural Rou	ıte Number,	,
Division of Vital	2 # # C	Certification:	4  Homicide	iniio <b>d</b>	build	ling, etc. (Spec	city)					City of	Own, State	"			
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	dicai C	(Check only 2 Medica	I Examiner:	On the b	e best of my ki	nowledge, de nation and/or	ath occurs investigation	d at the ti	me, date a opinion, de	nd place, ath occurr	and due to the	ne cause(s e, date and	and manner d place, and d	as stated tue to the	cause(s)	
	the thin 2 the 1	Med	29b. Signature and title of certific		and mar	nner stated.	12	7	ac. Licens	se number			29d. Da	te signed (Ma	nth, Day,	Year)	
	S O S		255. Signature and title of certifi		16	~	100		,	3435			S	eptembe	er 6,	2006	;
,	. ha l		Care	~	1 C	Longe	- 00	D=:=:					S.WR.	W-195			
l	ich		30. Name and address of person Aaron Kenigsbe	erg, M	.D.	1031	3 Geor	gia A		e, #3	07, 8	Silver	Spri	ng, MD	2090	)2	
	St Regist	ate trar	31. Date filed (Month, Day, Yea	<b>7</b> 200	6 32.	egistrar's Sig	nature	parti	1								

		1	1 - State Amend #5 Per	State of Market 10/0	aryland 4/06 JH	/ Departi	ment of H icate of I	ealth a Death	and Me	ental Hyg R	jiene 2 ()	06	30056
	Physici /Medic	. 70	1. Decedent's Name (First, Middle, La.	an Per	-T					2. Date of Dea Month	Day	Year DG	3. Time of Death 7:30 PM
	Examir	er	4a. Facility Name (If not institution, given SUNRISE SSES) 5. SMal Security Number 6. S	STED LIVE	WG e (In yrs. las		City, Town, or Under 1 Year		PARK	B. Date of Birth	Ann Ann	r A	PUNDAL place (State or Foreign
	Funeral Director			☐ M 20 <b>X</b> F	95		onths Days	Hours	Min.	Month, Day	, Year)	Cour	ntry) NJ
	land ow		10a. State 10b. County		10c. City, 7	Town or Locati	on					1	10d. Inside City Limits
	Many Firsh	to	MD Anne A	rundel			Arno	old					1 ☐ Yes 2 No
	th the	Director	10e. Street and Number				Of. Zip Code			1	l 0g. Citizen of W	/hat Cour	ntry?
	ath wi	la	32 Old Sturbridg	1				012				USA	
396	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show or other treumatic avent, the Madical Evantuar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 151 If Yes, Give Year or Dates:			Decedent of His, specify Cuba	ispanic Orig n, Mexican Specify:	gin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)	14. Race Black Specify.	k, White,	can Indian, etc. Vhite
21215-0036	hin 72 hou e. e. en *natura Medical E	Completed	15. Decedent's Ed (Specify only highest grade)			(Give kınd life. DO	's Usual Occupa d of work done o NOT use retired	during most )	-	9	16b. Kind of Bu		·
21	e filed within al Hygiene. I other then 'vent, the Mu	Com	9			Tel	.ephone				Bell		s
Maryland	should be filed ind Mental Hygid marked other umatic avent,	To Be	17. Father's Name (First, Middle, Last, Louis A. King							First, Middle,	Maiden Sumam	θ)	
Jar	2 sho		19a. Informant's Name/Relationship (								r, City or Town,		_
	s 1 and 2. if Health at Item 27 is other treu		Karen Salvatorie	TTO/Daugnt		32 OLC	l Sturbr	ridge	Road,		.d, MD 20c. Location -	2101.	
lor	ages nt of l		1 ☐ Burial 2 【Cremation 3 ☐		cem	netery, cremato	nry or other plac	θ)	Sep.	2,	Baltimo	1	
Baltimore,	permit. Pages 1 am Department of Heali Important: If Item 2 any injury or other once.		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		Meu		ame and Addres		ty	2000			neral Home D 21146
8760,	Physician /Medical Examiner  personal paralleusit  physician and personal price p	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	a consequer	nce of):	VA, A	IOVE	9NC	£D			Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3□Ect	opic pregnancy her (specify)				23d. Date Mor		ery Day Year
<u>α</u>	quires that n signed build be deta	ρχ	Part II. Other significant conditions of	contributing to death b	ut not resulti	ng in the under $ASC$	tying cause give	en in Part I.				ibute to th	he cause of death?
Vital Records,	The law requir cate has been si page 2 should	Completed	HYPERTEM HYPERLIPII							24a. Was a autops perfor	med2/ d	Vere auto rior to co leath?	opsy findings available impletion of cause of
ita	icien: Th certificate rector. pag	ВеС	25. Was case reterred to medicat examiner?						of Death	(Check only or		12	5/6-A
	Phys this ral di	2	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		8b. Time of Injury	28c. Injury Work	at at	28		ence 6-50the ow injury occurre		Y) LIVING
Division of	al or Attending s after death. Il Director: After ad in by the fune	Certification:	3 Suicide 6 Could not be determined		ury - At home c. (Specify)	e, farm, street,				Bf. Location (S City or Town		er or Rura	al Route Number,
	To the Mospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best niner: On the basis o and manner st	examination	edge, death oc n and/or invest	curred at the tin igation, in my of	ne, date and pinion, deat	d place, an	nd due to the c d at the time, d	ause(s) and mai late and place, a	nner as s and due to	stated. o the cause(s)
	To t Comp	Σ	29b. Signature and title of certifier	11.1			29c License	number	211	5	9d. Date signed	10	1-0-1
			· Mpull /-	HIM			レレ	46	SOL	1 1	Jugur	131	, 200b
	10		30. Name and address of person who Will CHAEL 131. Date filed (Month, Day, Year)	1 KNKP.	eath (Item 2: M ar's Signatur	D 860	OlVere	FANS	HIGH	MAJA	JULERS	ILLE	, 2006 MDZ1108
400	Sta Registi		SEP 0-5	600	a. o digitatul	2 L	and a						

			For State Registrar	State o	f Marylar	-	artment o			Mental Hy	giene Reg. No.	21111	3 0	057
	Physici		Decedent's Name (First, Middle,     Debra A. Peel							2. Date of De Month SEP	Day	Year 2.00	3. Time o	
7	/Medio Examir		4a. Facility Name (If not institution, St. Agnes	give street and nui			4b. City, To	m, or Local			4c.	County of Dea	th	
	Funeral Director		195–50–5526	5. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 49	last birthday) Yrs.	If Under 1 Months D	ear If Ur ays Hou	nder 24 Hrs urs Min.		y, Year)	9. Bir C	thptace (State country) PA	or Foreign
	and and		Usuat Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside C	ity Limits
	Mary -1 etc	tor	MD Anne	Arundel			Pas	adena					1 □ Yes	2 <b>X</b> No
	th the	Director	10e. Street and Number				10f. Zip Co	ede			10g. Citi	zen of What C	•	
	ath wi	ral	156 Oak Drive					2112					USA	
36	J within 72 hours after death with the Maryland Jiene. I then "neturel", or Iteme 23a or 28a-f ehow Itte Medical Examinar must be mattlied at	by Funeral	11. Marital Status  1 □ Never Married 2 🔀 Marrie  3 □ Widowed 4 □ Divorced	Armed Fo	2 No ve		Was Deceden If Yes, specify 1 ☐ Yes 2 🛭	Cuban, Me:	c Origin? (S xican, Puer <i>cify:</i>	pecify Yes or No to Rican, etc.)	ŀ	14. Race - Ame Black, Whi Specify: V		
9	72 hou	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usuat C	occupation	most of wo	deina	16b. Ki	nd of Business	/Industry	
21	within send the within send send send send send send send sen	Completed	Elementary/Secondary (0-12)	Colfege (	1-4or 5+)		DO NOT use i	etired)	111031 01 110	ining		***	-0.0	
2	be filed v tal Hygie d other t		17. Father's Name (First, Middle, L	ast)	1		Homen	1	fother's Na	me (First, Middle	Maiden		ome	
lan	d be ental ked o	To Be	Paul E. Brodbec							d Brown		,		
Maryland 21215-0036	d 2 sh th and 7 to m troum		19a. Informant's Name/Relationshi Christopher Pee	1	sband				_	ural Route Numb ena, MD	er, City or 211		Zip Code)	
Baltimore,	Pages 1 annent of Healt int: If Item 2 iry or other		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		State	Place of Disponentery, crein	natory or othe	r place)	Sep	Date 5 2006		cation - City or		
Baltii	permit. Pages of Department of Inportant: If Ite eny injury or of once.		21. Signa of Formal Service I						ons, chie	P.A. Sev Hwy, Sev				Home 146
			23a. Pa 1. Enter the disease, or o shock, or heart failure. List o	complications that only one cause on a	caused the dea						_		Approxima Interval Be	te
	Physician		Immediate Cause (Final disease or condition		tasta	tic B	sreasi-	Co	uraino	ama			Onset and	Death
	/Medical Examiner		resulting in death)	a	(or as a consec								,	
Н	Examiner	_	Sequentially list conditions,	b	for as a consec	wat of								
	rted	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D09 10	(or as a consec	querice or).								
ó	execu an and rial-tra	Exam	that initiated events resulting in death) Last	cDue to	(or as a consec	quence of):								
8760,	cate be executed bhysician and the burial-transit	dical	•	d										
9	entificating plans as the	/Med	fF FEMALE:	22a If yes out	toomo at progr	2001							Ш	
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live t	tcome of pregn pirth 2 Peta nant at time of d own	af death 3	Ectopic pregi Other (speci				2	23d. Date of de Month		Year
Ω.	that ed b deta	Ď	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying caus	e given in F	Part I.			se contribute to		
0.00	w requir been s should	eted								-	Yes 2		robably 4 🗍	
Vital Records,	The lay ete hes pege 2	Completed								24a. Was auto perfo 1 Yes	psy ormed?_	prior to death?	utopsy findings completion of c	avaitable cause of
Vite	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	/			Other		ath (Check only)	100			
of		٦. ت	1 Yes 2 No	10	inpatient 2 continuity of Injury th, Day Year)	28b. Time o		Injury at Work?	Nursing H	lome 5 Resi			icity)	
ion	Attending I r death. ector: After by the funer	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga		th, Day Year)	Infury	М	Work? 1 ☐ Yes	2 🗌 No					
Division	al or Attend s after death il Director: /	Certification:	3 Suicide 6 Could no determine	and 289. Place	of fniury - At hing, etc. (Speci	ome, farm, str	eet, factory, o	ffice		28f. Location ( City or To	Street and wn, State,	d Number or R )	ural Route Nun	nber,
	To the Hospital or within 24 hours after To the Funerel Director completely filled in the Funerel Director of the Funerel Dire	edical (	29a. Certifier 1 Certifying (Check only ane)	Physician: To the xaminer: On the b and man	a best of my know asis of examina ner stated.	owledge, deat ation and/or in	h occurred at t vestigation, in	he time, dat my opinion,	te and place death occu	a, and due to the urred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s	s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		HI			icense num			29d. Date	e signed (Mon	th, Day, Year)	
			* K la	ments	1-(1		P	176	07		SEF	01	2006	
	5		30. Name and address of person w			m 23a) (Type, ATO N		BA	LTIM	ore (	ND	2122	-9	
	Sta Registi		31. Date filed (Month, Day, Year)		gistrar's Sign	ature	hour							

ORIGINAL

			_ FOI	epartment of Health and N Certificate of Death	Mental Hygier	2006	30058
	Physici		1. Decedent's Name (First, Middle, Last) Walter Lenard Prediger		2. Date of Death Month September	5, 2006	3. Time of Death 7:17A. M
)	/Medio Examin	er	4a. Facility Name (If not institution, give street and number) Renaissance Gardens at Riderwood Village	4b. City, Town, or Location of Death Silver Spring		4c. County of Death Prince (	George's
	Funeral Director		5. Social Security Number 214-16-6899 6. Sex 1 $\mathbb{X}^{M}$ 2 $\square$ F 7. Age (In yrs. last birth 85 Yr	Months Days Hours Min.	8. Date of Birth NOV 23, 199	9. Birthp Mary	lace (State or Foreign Land
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Deperment of Heelih and Mental Hyglene. Importent: If Item 27 is marked other than "naturel", or Itema 23s or 28s-f show more in your or other treumatic avent, fra Modified Ear in a first mast te notified at anote.	Funeral Director	10e. Street and Number 3152 Gracefield Road, #103  11. Marital Status  12. Was Decedent Ever in U.S. Agmed Forces?	or Location  Pr Spring  10f. Zip Code  20904  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	Citizen of What Cour United St  14. Race - Americ Black, White,	ates can Indian,
Maryland 21215-0036	vithin 72 hours aft ne. han "natural", or a M. olical Exa. ili	Completed by F	(Specify only highest grade completed) ( Elementary/Secondary (0-12) College (1-4or 5+)	1 ☐ Yes 2 No Specify:  Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	king	Kind of Business/In	ŕ
and 21	d be filed wantal Hygies	Be	17. Father's Name (First, Middle, Last) Frederick Prediger		Na e (First, Middle, Maid h Baumeist		Insurance
Mary	nd 2 should the and Me 27 is mark	ဥ		Mailing Address (Street and Number or Ru. 18 Penrod Court Uppe			
Baltimore,	Pages 1 en ment of Hee ant: If Item		cemetery	oisposition (Name of crematory or other place)  d Veterans Cemetery		Location - City or To Cheltenha	
<b>Balt</b>	permit. Depertrimporte		21. Signature of Funeral Service Licensee	Bonala V. Bor Ward		Home, PA ille, Mary	
8760,	Physician and // // // // // // // // // // // // //	dical Examiner	23a. Part. End the disease, or complications that caused the death. Do no shock heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of conditions) curve the cause of the caus	al cord palsy	or respiratory arrest,		Approximate interval Between Onset and Death  1 week  1 week
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	quires that in signed b uld be deta		Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I,	23e. Did tobacc	o use contribute to t 2 □ No 3 □ Prot	57
Division of Vital Records,	in: The law requir ificate has been si or, page 2 should	e Completed	25. Was case referred to medical	26 Place of Dea	24a. Was an autopsy performed 1 Yes 2 X	24b. Were auto prior to co death? No 1 \(\sum Yes\)	psy findings available mpletion of cause of 2 No
Ž Ž	Physicien: r this certifica ral director, p	ToB	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outp		ome 5 Residence	6 ☐Other (Specil	y)
ision c	To the Hospital or Attending Physicien: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	Certification:	2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in 28f. Location (Street		al Boute Number
Ď	To the Mospital or A within 24 hours eftar To the Funeral Direction plately filled in by		3 Suicide determined 28e. Place of Injury - At home, fare building, etc. (Specify)		City or Town, St	ate)	
	he Hos in 24 ho he Fun pletely (	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.				
)	To the To the Complete	Σ	29b. Signature and title of certifier  by Lovery  Love	2 MD 29c. License number D59524	1	September	
/	9-11		30. Name and address of person who completed cause of death (Item 23a) (Toveen Puthumana, MD 3110 Gracefie		ng, Marylai	nd 20904	
	Sta Registi		31. Date filed (Month, Day, Year)  SEP 0 6 2006  32. Registrar's Signature	barle			

	1	- For State RegistræMEND#19aperFH9/6	State of Maryland 5/06,BMW,McCo		tificate of D		•	giene Z	2006	300
hysicia	n	1. Decedent's Name (First, Middle, Last)  Richard Powell					2. Date of De Month August	Day 24,	Year 2006	3. Time of Death 9:36 a
/Medica Examine		4a. Facility Name (If not institution, give str Shady Grove Advent			4b. City, Town, or Rockvil			4c. Cour	nty of Death	1
uneral irector		5. Social Security Number 6. Sex	7. Age (In yrs. las	,,,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 16	th	9. Birthp	lace (State or Fore
d other then "neturel", o	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last) Unknown	Terrace #B  Was Decedent Ever in U.S. Armed Forces? 1   Yes 2   No   If Yes, Give   Year or Dates: atton   College (1-4or 5+)	16a. Deced (Give k life. D Ret	pring  101. Zip Code  20904  Vas Decedent of His Yes, specify Cubar  Yes 2 No  ent's Usual Occupa kind of work done di DO NOT use retired)  ail Aid	n, Mexican, Puerto Specify:  tion most of work  18. Mother's Nam Unknow	Rican, etc.)  ing  e (First, Middle	Special 16b. Kind of NO Maiden Sum	of What Cour  ted St lace - Americ lack, White, city: Cau Business/Inc  n-Prof	ates an Indian, etc.  casian dustry
sician ledical aminer listration	Examiner	19a. Informant's Name/Relationship (Type Veronica Lawrence  20a. Method of Disposition  1	Asé Manager /No relation  20b. Pia cen  proval from State  Ft. ]	8905 ce of Disposinetery, crem Lincol 22 Si 04 Do not ente	ntion (Name of latory or other place In Cremato Name and Address Imple Trib O Rockvi	Road; Si ory 9/07 s of Facility oute Func lle Pike;	llver Spoate 7/2006 eral and Rockvi	pring, 20c. Locatio Brentw d Crema ille, M	MD 209 n-City or To	910 wn, State Maryland
been signed by the ettending should be detached for use as	Completed by Physician/	JF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown  Part II. Other significant conditions contributed in the past 12 months?  Mental Retardations		éath 3□ th 5□			24a. Was autoj perfo 1 Yes	obacco use co	3 ☐ Prob	Day Year  ne cause of death?  ably 4 Unknot  psy findings availa  npletion of cause
this certain direct	0 8			R/Outpatient 8b. Time of Injury e, farm, stre	3 DOA Other 28c. Injury Work M 1 Y	at ?	me 5 Resi	dence 6 00 how injury occ	urred	l Route Number.
= 8	edicai	29a. Certifier 1  Cartifying Physic	cian: To the best of my knowl	edge, death n and/or inv	occurred at the time	e, date and place,	and due to the red at the time,	cause(s) and	manner as st	ated.

			1 - For State Registrar		State	of Marylar				lealth a		_	giene Reg. No.	2000	3.0	กรถ
			Decedent's Name (First, Middle	, Last)								2. Date of De	ath		3. Time of	Death
	Physici /Medic		Beatrice			Reid						Month August	Day 31,		2:00	рм
	Examin		4a. Facility Name (If not institution	, give str	eet and nu	ımber)		4b. Cit	y, Town, or	Location of	of Death		4c.	County of Death		
			Fox Chase Reha		Nurs				silvei er 1 Year	spr		0.0			gomery	
	Funeral Director		5. Social Security Number 579-22-3588	6. Sex 1 □ N	<b>¥</b> ⊠F	7. Age (In yrs. 89	Yrs.	Month		Hours	Min.	8. Date of Bir (Month, Da	y, Year)		place (State o	
Ш			Usuel Residence of Decedent			0,5		l	J	1		June 5,	191	/ Souti	n Carol	.ina
	how		10a. State 10b. County			10c. Ci	ty, Town or Lo	cation							10d. tnside Cit	
:	8s-1-	Directo	Florida	Vol	usia			F	ort (	Orange	e				1 🗆 Yes	2 1 No
:	or 2	E	10e. Street and Number	C-1	Q	. 7 -		10f. 2	ip Code				10g. Citi	zen of What Cou	•	
	72 hours after death with the Maryland "natural", or flems 23a or 28s-f ehow idical Examinar must be notified at	Funeral	1341 Calle Del			STE	IS 13	Was Dec		32129	igin? (Spe	city Yes or No		USZ 14. Race - Amer		
	iner d	F.	1 Never Married 2 Marr		Armed F 1 ☐ Yes	orces? 2 <b>K</b> No						cify Yes or No Rican, etc.)		Black, White		
3	raf', o	þ	31☑ Widowed 4 ☐ Divorced		If Yes, G Year or I	ive Dates:		1 ∟ Yes	2√ No	Specify:				Specify:Whit	e	
ק ה	n 72 hours "natural", adical Exp	Completed	15. Decedent (Specify only highes			)	16a. Dece (Give	kind of v	vork done d	during mos	t of workii	ng	16b. Ki	nd of Business/li	ndustry	
7	hen.	ig m	Elementary/Secondary (0-12)		College	(1-4or 5+)			use retired	1)						
V	filed within Hygiene. Ither then " int, the Mei	ပို	12 17. Father's Name (First, Middle,	Last)			_Wait	ress		18. Mothe	er's Name	(First, Middle		d Servio Sumame)	:e	
	Med o	To Be	John Thomas L		r					Ar	nnie	France	s Nea	a 1		
	should ind Men marke umatic	-	19a, Informant's Name/Relations				19b. Maili	ng Addre	ss (Street					r Town, State, Zi	p Code)	(/2
	and 2 salth a n 27 is		Joyce Whitney/	Nie	ce		1341	Cal	le De	el Sol	l Cir	cle, P	ort (	Orange,	FL 321	29
<u> </u>	-195		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Por	noval from	1	Place of Dispo cemetery, cre	osition (N matory o	ame of other plac	(e)		ate	20c. Lo	cation - City or T	own, State	
	Pages ment of ant: If it		4 ☐ Donation 5 ☐ Other (S	oecify)		Arl	ington N	ation	al Cem	etery		t. 18,	Arli	ngton, V	irgini	4
- B	Deporting Deporting Importing any ni		21. Signature of Funeral Service	Licensee		00								me Inc.		
_	403 e d		James	2	C	20 Kat	5	OO U	niver	sity	Blvd	, W, S.	ilve	r Spring	Approximate	
			23a. Part1. Enter the disease, or shock, or hear failure. List Immediate Cause (Final	only one	cause on	each line.	th. Do not en	ter the m	ode or dylin	ig, such as	cardiac o	respiratory a	rrest,		Interval Bets Onset and I	ween
ľ	hysician /Medical		disease or condition resulting in death)	_ a.		stive H		ailu	re						3	Month
ı	Examiner			1		o (or as a consec Cosclero		art	Dicas	50					2900	Year
		Jer	Sequentially fet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ь.		(or as a consec		art	DIBEG	.se					1	I Cal
	cuted nd ransit	Examin	that initiated events	С.												
o,	be exe icien ar burial-t	EX	resulting in death) Last		Due to	(or as a conse	quence of):									
0	ate hys	dicai		d.							_		_			
XO	leath certificate attending phys I for use as the	/Me	IF FEMALE:	230	tf ves o	utcome of pregn	ancy							22d Date of delic		
2	ath or u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	200	1 Live	birth 2 Fet	al death 3	Ectopic Other (	pregnancy	'			4	23d. Date of deliver Month	•	/ear
į į	0 0 0	lsk	1 □ Yes 2 版 No 9 □ Unknown		9□ Unk											
7.	requires that the een signed by th nould be detache	by PI	Part II. Other significant condition	ns contr	ibuting to	death but not re	sulting in the u	inderlying	cause giv	en in Part I	l.	23e. Did t	obacco u	se contribute to	the cause of d	eath?
cords	w require been sig should b	edit	Atrial Fibrilla	ation	1							10	Yes 2	JNo 3□Pro	bably 4 🔼	Inknown
ပ် ၿ	<u> </u>	piet										24a. Was		24b. Were aut prior to o	opsy findings a	avaitable
r	The ete h page	Completed										perfo	ormed? 2⊠No	death? 1 ☐ Yes		
	Physician: rthis certific ral director,	Be (	25. Was case referred to medical examiner?	-							of Death	Check only	опеј			
5	hysi this c aldire	2	1 ☐ Yes 2 ☐ No	но			ER/Outpatie			467 146				3 ☐Other (Spec	fy)	
	After funer	lo	27. Manner of Death 1 ⊠Natural 5 □ Pendin		28a. Date (Mo	nth, Day Year)	28b. Time of Injury	M	28c. Injun Wor	yat k? Yes 2. ☐		28d. Describe	now intur	y occurred		
VISION	Attending Plinders Plinders Plinders Attenti	licat	2 Accident investig	not be	28e. Ptac	e of Injury - At h	ome, farm, st			.03 20		28f. Location (	Street an	d Number or Ru	al Route Num	ber.
2	after after Dire	Certification:	4 ☐ Homicide determ	med		ding, etc. (Spec			,, ccc			City or To	wn, State	)		,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	aic	29a. Certifier 1 <sup>™</sup> Certifyir	g Physic	ian: To th	ne best of my kn	owledge, deat	h occurre	ed at the tin	ne, date ar	nd place, a	and due to the	cause(s)	and manner as	stated.	
	n 24 he Fu	edicai	(Check only 2 Medical one)	Examine	and ma	basis of examin nner stated.	ation and/or in	vestigati	on, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and due	to the cause(s	)
	Vithi To t Com	Σ	29b. Signature and little of certifie	r				2	9c. Licens					e signed (Month		
	2		tars						D28	00b			Se	ptember	6, 200	)6
	3		30. Name and address of person Ravi Passi, M.						#101F	0:1		Constant	B # F	2007.0		
	-61		31. Date filed (Month Day, Year)			9 Secon		ie,	†4U4B	, bil	ver	spring,	MD	703T0		
	Sta Registi		SEP -	7 20		6	M A	And N	,							

State

Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

60

. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Dav Year	3. Time of Death
Robert Henry Rogers	SEPT.	1 2006	1430 M
Al. A Line A Land	1		•
Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth		nplace (State or Foreign untry)
1 M 2 F 88 Yrs. Months Days Hours Min.			Laware
			10d. Inside City Limits
			1XXYes 2 ☐ No
	] 1	log. Citizen of What Co	untry?
4 West Elizabeth Street 21875		U.S.A.	
	pecify Yes or No-	14. Race - Ame	
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No	o i noun, oto.,	Specific	
3 ☑ Widowed 4 ☐ Divorced Year or Dates:			white
(Specify only highest grade completed) (Give kind of work done during most of wo	rking	166. Kind of Business/	industry
Elementary/Secondary (0-12) College (1-4or 5+)		Trucking C	ompany
	me (First, Middle,	Maiden Sumame)	
Unknown Emma	(maiden	name unkno	own)
1 X Burial 2 Cramation 3 Removal from State cometery, crematory or other place)		·	
Gardens	2006	Hebron, Ma	aryland
Short Funeral Home	1 5	T 100/0	
			Approximate
	,		Interval Between Onset and Death
disease or condition  a			
Sequentially fist conditions, fany, leading to immediate Due to (or as a consequence of):			
mat initiated events C.			
Due to (or as a consequence of):			
d			
23c It was outcome of pregnancy		22d Date of do	ivan
in the past 12 months?		Month Month	Day Year
1 UYes 2 UNO 9 Unknown			
	23e. Did to	bacco use contribute to	the cause of death?
(Mahetes	1 □ Y	es 2 □ No 3 □ P	obably 4 Unknown
		an 24b. Were at	utopsy findings available completion of cause of
	perfor		
25. Was case referred to medical 26. Place of De	ath (Check only o		
	Home 5 Resid	lence 6 Other (Spe	cify)
- 11 / C / C / C / C / C / C / C / C / C	28d. Describe h	low injury occurred	
27. Manner of Death 28a. Date of Injury 1 Waturat 28b. Time of 28c. Injury at Injury Work?	1		
2 Accident investigation M 1 Yes 2 No	201	Street and North	uml Douge Alumbas
M 1 Vas 2 No	281. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
2 Accident 3 Suicide 4 Homicide    March   Suicide   Sui	City or Tow	vn, State)	
2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	City or Tow	vn, State)	stated.
2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  1 Cartiflier (Check only  1 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	City or Tow	vn, State)	s stated a to the cause(s)
2   Accident 3   Suicide 4   Homicide  28e. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  29e. Certifler (Check only one)  29d. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifler 29b. Signature and title of certifler 29c. License number	City or Tow	m, State)  cause(s) and manner a date and place, and du  29d. Date signed (Mon	s stated to the cause(s)
2   Accident 3   Suicide 4   Homicide  28e. Pface of Injury - At home, farm, street, factory, office  29a. Certifier (Check only one) 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 2   Signature and title of certifier 3   Suicide 4   Homicide 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 3   Suicide 4   Homicide 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 3   Suicide 4   Homicide 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 3   Suicide 4   Homicide 4   Homicide 5   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 4   Suicide 5   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 4   Suicide 5   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 5   Suicide 6   Suicide 7   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at title of certifier 7   Suicide 8   Suicid	City or Tow	m, State)  aussels, and manner a date and place, and dure  29d. Date signed (Mon.)	s stated to the cause(s)
2   Accident 3   Suicide 4   Homicide  28e. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and title of certifier 4   Check only one)  29c. License number 4   Check only one)  29c. License number	City or Tow	m, State)  aussels, and manner a date and place, and dure  29d. Date signed (Mon.)	s stated to the cause(s)
5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4a. Facility Name (if not institution, give street and number)  ANNUSULA ADJONES MALE AND ADJONES AND	4. City, Town or Location of Death	4a. County of Death Multipublic Name (If not institution, give streat and number) Multipublic Name (If not institution, give streat and number) Multipublic Name (If not institution, give streat and number) 6. Sex

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 30063 Reg. No. 2 0 0 5 Certificate of Death 3. Time of Death a 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph Rausch Jr. Edward 2006 September 5, 1:53 М /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 1108 S. Schumaker Dr. Salisbury 9. Birthplace (State or Foreign Country) Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/12/1911 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**⅓**M 2□F Months 94 536-10-1054 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location. 10d. Inside City Limits 10a State 10h County or 28a-f show Examiner must be nutified at ¥ Yes 2 No Director Salisbury Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21804 USA 1108 S. Schumaker Dr. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. . Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. Then of Health and Mental Hygiene. white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry other traumatic event, it a Madical Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Wholesale Grocery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irma Louise Devendorf Joseph Edward Rausch Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bernadette A. Rausch/wife 1108 S. Schumaker Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory 9/6/06 Salisbury, MD 4 □ Donation 5 □ Other (Specify) permit.
Departimports
any int LEmeral Service Licensee Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 aire H. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metas MAIC Immediate Cause (Final (ancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner A(ev) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal deal 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) been signed by the s should be detached Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No this certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifics Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 3□ D**O**A 2 ER/Outpatient P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident sompletely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 916106 NULLA 047094 S. O 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21804 SAZISBUAY sheer 1415 NATESAN 5- DIVISION vel 32. Resistrar's Signature 31. Date filed (Month, Day, Year) SEP 0 State 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 30064 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** SEP 2006 Morris Ronald Rudo 1945 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. Director 578-46-5384 D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 832 Quince Orchard Blvd. #201 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Btack, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene emportant: if item 27 is marked other then any injured other then any injured other. Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samue 1 Rudo Weinstock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 832 Quince Orchard Blvd.#201 Gaithersburg, MD 20878 Roslyn R. Waldman/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/6/2006 Beltsville, Maryland 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, MD 21. Signature of Funeral Service Licenses Mar M00956 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Amyot /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician a detached for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗌 Unknown sate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 1 Yes 2XNo funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Watural 5 Pending 1 Tyes 2 No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item a) Rockville Pike, G-100, Rockville, MD 20852 Vay, M.D. omsko atricia 31. Date filed (Month, Day, Year) SEP 0 6 egistrar's Signature State 06 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo o o

			1 - For State Registrar	State of Ma	arytanu / D	eparim <i>Certific</i>	ent of H ate of L	Death	mentai Hy	giene Reg. No	2006	30	065
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month	eath Da	y Year	3. Time of	
	/Medi	cal	Helen J.  4a. Facility Name (If not institution, give		mond	4b C	Site Town or	Location of Deat			3, 2000 County of Dea		рм
1	Examir	ier	13804 Lakeside			40.0		sville	11	40	. County of Dea	Howard	
	Funeral Director		379-03-0620	ex 7. Ag □M 2 🗗 F	88 Y	rs. If Ur	nder 1 Year ths Days	If Under 24 Hrs Hours Min.		ay, Year)	9. Bir Co 1918 Ma	thplace (State ountry) aryland	or Foreign
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside C	ity Limits
	e Man	ctor	Maryland Howard		(	Clarks	ville					1 ☐ Yes	2 🔀 No
	th with th	ai Dire	10e. Street and Number 13804 Lakeside	Drive		10f.	Zip Code 21029	)		10g. Ci	tizen of What Co USA	ountry?	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural", or items 23a or 28a-f show minipury or other treumatic event, its Madical Exactinar must be rediffied at ODGS.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Nover 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			ecedent of Hi specify Cuba s 28 No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	D-	14. Race - Ame Black, Whit Specify: V		
20	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. [	Decedent's U	Jsual Occupa f work done of	ation furing most of wo	rking		(ind of Business	•	
121	within lene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			) Nistrato:			ntgomery vernment	-	У
	e filled Il Hygi other	Be C	17. Father's Name (First, Middle, Last)				11021	18. Mother's Nar		4			
ylar	Menta Menta arked atic e	ToE	Albert N. Jones					Bessie	Clare G	arri	son		
Maryland	d 2 shi th and 7 ie m treum	1 4	19a. Informant's Name/Relationship (					and Number or Ru		-			
	s 1 an if Heal item 2 other		Linda L. Aluise		20b. Place of I	Disposition (	AKESIO	le Drive,	Date		_e MD 2 ocation - City or		
<u><u>E</u></u>	Page ment of the state of the s		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Parkla				Sept. 7, 2006	Rock	ville,	Marvlar	nd
Baltimore,	Depart Import any inj		21. Signatury of F, neral Service Licen	500 Col	e	Fran 500	e and Addres Cis J. Univer	s of Facility Collins sity Bly	Funera	1 Hc	me Inc.		
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	sications that caused one cause on each lin	the death. Do no						•	Approximat Interval Bet	e ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Adenocar			g, Sta	ge IV				9 Mont	
	Examiner				a consequence of	·):							
	р <del>Ц</del>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	to semesuper ros of	7							
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	1.							
68760	tificate be executed ig physicien and as the burial-transit	edicai E		d		,. 							
89 ×			IF FEMALE:										
.O. Box	The law requires that the death cert lie has been signed by the attending age 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopi 5 □ Other	c pregnancy (specify)				23d. Date of del Month		Year
а.	w requires that been signed b should be deta	þ	Part II. Other significant conditions of Anemia, Anorexia	ontributing to death bu	it not resulting in t	the underlyin	ng cause give	on in Part I.			use contribute to		
Vital Records,		Completed			-						prior to death?	utopsy findings completion of c	available ause of
/ita	sician: certific rector,	Be	25. Was case referred to medical examiner?						th Check only				
ō	Phys this ral dir	5	1 ☐ Yes 2 ②XNo  27. Manner of Death	Hospital: 1 ☐ Inpatie			DOA Othe	4 Li Nui Siriy F	ome 5 X Resi			cify)	
Division	ding After fune	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day	Year) Inj	ury M		at ? ∕es 2 □ No	28d. Describe	now injui	ry occurred		
Σ			4 Homicide determined	building, etc	. (Specify)				City or To	wn, State			ber,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) Certifying Physics (Check only one)	ysician: To the best of liner: On the basis of and manner sta	examination and	death occur or investigat	red at the tim tion, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause(s	)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mailler sta			29c. License	number		29d. Da	te signed (Monti	h, Day, Year)	
	10		> youk. r	nul			D 30	5573			Septeml	ber 5,	2006
	•	1	30. Name and dress of person who a Jon Minford, M.D.		ittle Pa	tuxent		way, Col	umbia, I	MD 2	1044		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 6		r's Signature	Spark	r)						

State of Maryland / Department of Health and Mental Hygiene 2006 30066 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Flegnar Rose, September 2006 12:52P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clinton, Maryland If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 55 Director 243**-**84-4134 9/14/1950 Goldsboro, NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 ie marked other then \*neturel', or Itame 23a or 28a-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits if Health and Mental Hygiene.
Item 27 is marked other then "neture!", or Itame 23s or 28s-f show other treumstic event, the Modical Examinar must be notified at Maryland Prince Georges District Heights 1 XYes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2506 Overdale Place 20747 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status V Yes 2 No IKYes, Give 1970 −71 Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Ď 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Long Distance Trucker Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Flegnar Rose, Sr. Blossie Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delois Rose (Wife) 2506 Overdale Place, District Heights, MD 20747 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition MD Veterans Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/2006 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 5538 Marlboro Pike, Forestville, MD unmans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical as the the ettending phase as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performed certificete 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ ZX ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M Accident filled in by the 6 Could not be determined 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 24 and manner stated. To the within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dwayne Thompson, M.D., 7503 Surratts Road, Clinton, Maryland 20735 Dwayne Thompson, M.D., 31. Date fifed (Month, Day, Year) SEP 0 8 2006 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Maryland		irtment <i>tificate</i>			d Mental F	lygien Reg. No	2006	30067
			1. Decedent's Name (First, Middle, Last)						2. Date of Month			3. Time of Death
	Physicia /Medic		WARJORIE	STINCH	1001	W.B			Sor	Morr	05 Zon	3.30PM
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, T	own, or	Location of De	ath	40	. County of Death	
			Shedy Go	ue Aduct	765		ROCK	CVILLE			MONTGOMER	Y
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Months	Year Days	If Under 24 H Hours M		Birth Day, Year	9. Birth	place (State or Foreign
	Director		3/9-26-1528	82	Yrs.				JUNE 1			YLÁND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Loc	cation						10d. Inside City Limits
	Aaryli Peho	ក	MARYLAND MONTGOMERY			KVILLE						1 ☐ Yes 2 🛣 No
	28a-	Director	10e. Street and Number		ROC	10f. Zip C	Code			10g C	tizen of What Cou	ntn/?
	with Sa or			<b></b> ‡109				0850		lug. O		
	ns 23	Funerai		2. Was Decedent Ever in U.S	i. 13. V	Vas Decede	nt of Hi	spanic Origin?	(Specify Yes or	No-	U.S.A.	can Indian.
0	riter	교	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No	-				erto Rican, etc.)		Black, White	etc.
3	ei', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2	△ No	Specify:			Specify: WHI	TE
5-003	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f ehow he Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ent's Usual	Occupa	ation during most of v	vorkina	16b. k	(ind of Business/I	ndustry
7	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. C	O NOT use	retired	)	· onling			
7	filed w Hygier other th	ខ្ល	12		SUPE	RVISOR					ETRO TRANS	IT
aud	be fill H d ott	Be	17. Father's Name (First, Middle, Last)						lame (First, Mid		n Sumame)	
2	should nd Men marke	၉	ELDER T. STINCHCOMB  19a. Informant's Name/Relationship (Typ)	- Crist	405 14 17		(2)		TA WARRING			
2	d 2 sl th an 7 ie r traur		, , , , ,	e, Frinty							or Town, State, Zi	·
ย์	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 ie marked other than "naturel", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at		LAURIE NILSEN - NIECE  20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name	e of	- T	Date		YLAND 2114 ocation - City or T	
2	permit. Pages 1 Department of H Important: if ite eny injury or ott		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	metery, crem	atory or oth	er place		0.10006			
Dalitimo	artme ortan injur		21. Signature of Funeral Service Licensed	1	RY UMC	Name and			9/2006		OLD, MARYL FUNERAL HO	
Ď	Ded Gray		James A	len on -				u estate estate estate estate estate estate estate estate estate estate estate estate estate estate estate est				KYLAND ZU904
			2.a. Part1. En er the disease, or complic	ations that caused the death.					-			Approximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final	_ ~	-	- AC	~ <del>-</del>	- 0;	ncil			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque		(SA)	21	20	OCK			HOURS
	Examiner		Commentally list and divine	A CUTE 1	OFN	CXC	9/6	H IN	JEARC	TOIL	2	YAC )
+	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):							
	and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last									
9/00,	cate be executed physicien and the burial-transit		1030king in doutily East	Due to (or as a conseque	ence of):							
0	ficate be executed physicien and s the burial-transit	dicai	d.									
XO	nding l	Physician/Me	IF FEMALE:	c. If yes, outcome of pregnan	cv						22d Date of deli-	
0	death e atten	cian	in the past 12 mgnths?	1 Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3□	Ectopic pred					23d. Date of delive Month	ery Day Year
į	y the	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		other (apor	···//					
_	The law requires that the death certif ate has been signed by the attending page 2 should be deteched for use a:	by P	Part II. Other significant conditions cont	ributing to death but not result	ting in the un	derlying cau	use give	n in Part I.	23e. Di	id tobacco	use contribute to	he cause of death?
S.	quire in sig uld b		MADERTENS	LON					1	☐Yes 2	ØNo 3□Pro	ably 4 □Unknown
2	s bee	Completed							24a. W		24b. Were aut	opsy findings available
Ĕ	The la te ha	E							pe	itopsy erformed?	death?	impletion of cause of
<u> </u>	an: rtifica for, p	0	25. Was case referred to medical	W				26. Place of D	eath Check on	s 2.⊠No Vonel	1 1 105	22 140
>	ysicl lis ce direc	10 B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☑Inpatient 2□E	R/Outpatient	3□ DOA	Othe	· ·			6 ☐Other (Speci	fv)
5	ng Pt Iter th neral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury Work		28d. Describ			
VISIOII	endir eath. or: Al	atic	2 Accident investigation			М		res 2 □No				
Ĕ	r Att ter de irect	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory,	office			n (Street al Town, State	nd Number or Rur e)	al Route Number,
ב	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the tuneral director, page 2	O										
	Hoss 24 ho Fune fely fi	edical	29a. Certifier 1. Certifying Physi (Check only 2 Medical Examine	cian: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at estig <i>a</i> tion, i	t the tim n my op	e, date and pla sinion, death oc	ce, and due to the curred at the time	he cause(s ie, date <i>a</i> n	) and manner as : d place, and due t	stated. o the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and mainer sidled.		29c.	License	number		29d. Da	ite signed (Month,	Day, Year)
)	F ≯ F 8		1 Jan Solt	MD		1			954	1		2006,2006
	10	ŀ	30. Name and address of person who com	npleted cause of death (Item 2	23a) (Type: F	Print)						
	10			OSD YOAM		かびを	トリ	17 H	025150	40,	nock	ました
0	Sta Registr		31. Date filed (MSEPay, Year) 7 20	32 registrar's Signatu	K An	artes						
	n1240112911	- 1	•	A A STREET AND A STREET		17.0						

Physi /Med Exam

Funera Directo

1 - For State Registrar	<u> </u>	State o	f Marylar		artmen rtificate					Reg. No	7111	16	30068
1. Decedent's Name (F	First, Middle,	Last)							2. Date of D Month	Da	y \	rear	3. Time of Death
li	Shanno				T				Septer				10:35p M
4a. Facility Name (If no	ot institution, g	give street and nu	m <i>ber)</i>				Location	of Death		4c.	County of	i Death Egom	erv
Collingsw 5. Social Security Numl	ood Nu	rsing &	Rehab. 7. Age (In yrs.	last hirthday		kvil	.1e If Under	24 Hrs	8. Date of B	irth			lace (State or Foreign
579-10-63	22	.Sex 1 ☐ M 2 ☐ F		37 Yrs.	Months	Days	Hours		April .	ay Year)	919	Coun	yland
Usual Residence of De								1	-F				
10a. State 10	0b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside City Limits
Maryland	Montg	omery		Silv	er Sp	ring	ſ						1 ☐ Yes 2 🚰 No
Maryland  10e. Street and Numbe  3121 Beck  11. Marital Status  1 Never Married  3 Widowed 4 (Specify to Specify to Speci	or				10f. Zip	Code				10g. Cit	izen of Wh	at Coun	try?
3121 Beck	enham	Court				2	0906				USA		
11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.	Was Deced	ent of His	spanic Or	igin? (Spe	cify Yes or N Rican, etc.)	10-	14. Race	- Americ White,	
1 Never Married		1 1 Yes Gi	2 □ No		1 Yes		Specify		, ,		Specify:		
3 ☐ Widowed 4 ☐	Divorced	Year or D	oates: WWI]	E		A- · · ·					CPCCy.	MILL	
15 (Specify o	<ul> <li>Decedent's only highest ;</li> </ul>	Education grade completed)		(Give	dent's Usua kind of wor	rk done d	lurina mos	st of worki	ng	16b. K	ind of Bus	iness/Ind	dustry
Elementary/Seconda	ary (0-12)	College (	1-4or 5+)		DO NOT us						_	_	
12 17. Father's Name (Fire	et Middle I s			Logi	stics	Off			(First, Middle				ernment
		_									i Sumame,	,	
Middleto						10	-		na Skir				
19a. Informant's Name					-				I Route Numi				,
Marcia B.		on/ Wife		3121 Place of Dispo			ım Co		Silven	_			
20a. Method of Disposi		☐Removal from	l l	cemetery, cre	matory or o	ther place	9)		mber 7	200. L	ocation - C	ity or 10	wn, State
4 □Donation 5			Gat	e of Hea			~		006				g, Marylan
21. Signature of Funer	- 11 1	censee							Tuneral				MD 20901
23a. Part1. Enter the d	disease, or co	omplications that	caused the dea	th. Do not en	ter the mod	e of dying	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between
Immediate Cause (Fin		nly one cause on e			_							Į.	Onset and Death
disease or condition resulting in death)			osclero		rebro	vasc	ular	Dise	ease		·		
	1		tensior										
Sequentially list condit if any, leading to imme	tions.	b	(or as a consec									_	
cause. Enter Underlying Cause (Disease or injustrational initiated events	na 🚄												
f any, leading to imme cause. Enter Underlyi Cause (Disease or inju- that initiated events resulting in death) Last	t	c. Due to	(or as a consec	quence of):									
ll.													
		U			-								
IF FEMALE: 23b. Was decedent pro	regnant	23c. If yes, ou	tcome of pregn								23d. Date	of delive	ırv
in the past 12 mo	onths?		oirth 2 Feta		□Ectopic pr □ Other (sp						Mont		Day Year
9 Unknown	10	9□ Unkn	own										
Part II. Other significa	nt condition	s contributing to d	leath but not re:	sulting in the u	inderlying c	ause give	n in Part	I.	23e. Did	tobacco	use contrib	oute to th	ne cause of death?
IFFEMALE: 23b. Was decedent properties to the past 12 months of th	Dement	ia							1 🗆	Yes 2	□No 3	☐ Prob	ably 4 <del>∑</del> ∭rnknown
									24a. Wa	6 20	24h W	are auto	psy findings available
							-		auto	opsy formed?	pri	or to cor ath?	npletion of cause of
J <del></del>										2 🗀 No		Yes	2□ No
25. Was case referred examiner?		Hospital:			_	Othe			(Check only				
1 ☐ Yes 2% No		10	Inpatient 2			A Care	4 ⊠ N		ne 5□Res				()
	5 Pending		of Injury th, Day Year)	28b. Time o Injury	M 2	8c. Injury Work	at ? Yes 2. □		28d. Describe	now inju	ry occurre	3	
2 Accident	investiga 6 □ Could no	t bo	of Injury Art	nome form -			. 03 2 _		28f Location	/Stract c	ad Number	or D	l Route Number,
4  Homicide	determin	ed build	e of Injury - At h ling, etc. <i>(Speci</i>	ify)	reet, ractory	, once				own, State		Ur Aura	Andre Mariber
29a. Certifier 1	XCertifying ☐ Medical Ex	Physicien: To the kaminer: On the b and man	e best of my kn basis of examination	owledge, deal ation and/or in	h occurred ivestigation	at the tim	e, date a pinion, de	nd place, a	and due to the	e cause(s ), date an	) and man d place, ar	ner as st	ated. the cause(s)
29b. Signature and title	eof certife)	AAA.					number			29d. Da	te signed	(Month,	Day, Year)
N VOI	////	11/1/			14	-45	83	19		Sent	ember	6.	2006
30. Name and address					Print)					~ CPC		,	
Gary Raff			. West (		ane,	#202	, Be	these	da, MD				
31. Date filed (Month)		- 4	Registrar's Sign		ast,								
01				- 19									

DHMH 17 Rev 1/2001

Registrar

		,	For State Registrar	State of Ma	ryland / Depa. <i>Cer</i>	irtment of H tificate of L	ealth and M Death		iene <sub>99. No.</sub> 2 0 0 6	30069
	Physicia	an	1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic	al		ar1	Sigri		1	Septembe	er 3, 2006	
	Examin	er	4a. Facility Name (If not institution, gi 7790 Hayward Ro			Pocomoke	Location of Death		Somerset	un
	Funeral				(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9 Bir	rthplace (State or Foreign ountry)
	Director		218-16-04/5	1A M 2   F	86 Yrs.	Willias Days		07-02-19		yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary a-1sh	tor	MD Somerse	t	Pocomoke					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	ountry?
	s 23a	rai	7790 Hayward Ro	ad 12. Was Decedent E	12 V	21851	anania Origina (Co.	arif. Was as No	USA 14. Race - Am	oriona la disa
	fter de	by Funerai	11. Marital Status 1 ☐ Never Married 2 ★ Married	Armed Forces?  1 Nes 2 Nes 1 Yes, Give	0	Vas Decedent of Hi Yes, specify Cubar		Rican, etc.)	Black, Whi	
93	ral, o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII 1	Yes 200 No	Specify:		Specify:	hite
Maryland 21215-0036	filed within 72 hours atter death with the Maryland Hygiene. ther then "natural", or terms 23a or 28a-f show that the Mudical Evanil actinual technolified at	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)	(Give	ent's Usual Occupa kind of work done d OO NOT use retired.	luring most of work	ing	16b. Kind of Business	/industry
12	withir ene. then	duc	Elementary/Secondary (0-12)	College (1-4or 5- 4	·)	1 Teache			Agricultur	•
<b>d</b> 2	il Hygi other	Be C	17. Father's Name (First, Middle, Las	t)	SCHOOL	or reactie	18. Mother's Name			е
ylar	Menta Menta arked atic ev	To B	Joseph A. Sigris	t			Verena A	nna von	Ah	
Mar	12 short and 7 Is m.		19a. Informant's Name/Relationship  Joyce Webster Si			g Address (Street a Hayward l			City or Town, State,	Zip Code)
e,	1 and Health tem 2;		20a. Method of Disposition	grist/wire	20b. Place of Disposemetery, crem				20c. Location - City o	Town, State
ē	Pages ent of nt: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		Quinton (		9-7-2	006 F	Pocomoke,	Marvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or flems 23a or 28a-f show any filury or other traumatic event, the Mudical Eventimet in the indiffed at once.		21 Signature of Funeral Service U.c.	insee -	The second secon	Name and Addres				
_	80 5 5 9		AMES BLU		00295 11	673 Somer	set Ave.	Prince	ss Anne, N	4D 21853
		-	231. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line	θ.		g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	Renal consequence of):	Failur				
	Examiner		Out to the first are divisor.	b 500 to (0) 23 2	ASCUD					
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying	Due to (or as a	consequence of):					
	xecute and al-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
8760,	rate be executed thy sician and the burial-transit	dicai Examiner		d						
9	rtificat ng phy as th		IF FEMALE:				107			
Box	death certific e attending p ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Petal death 3 ☐	Ectopic pregnancy			23d. Date of de Month	livery Day Year
P.0.	the de y the a	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 5 L	Other (specify)				
۵.	The law requires that the death ate has been signed by the atte page 2 should be detached for	by Physician/Me	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	iderlying cause give	on in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ords	w require been sig should b							1 ☐ Ye	os 2.⊠No 3.∏P	robably 4 Unknown
ecc	has be	Completed						24a. Was ar autops	y prior to	utopsy findings available completion of cause of
al H								perform 1 Yes 2	No 1□Yes	s 2□No
Z:	Physician: r this certificaral director.	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \overline{\mathbb{Z}} No	Hospital:	nt 2 ER/Outpatien	t 3 DOA Cthe	26. Place of Death		e) ence 6 □Other <i>(Spe</i>	20(54)
ا م	ig Phy ler this	h	27. Manger of Death	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Work	at		w injury occurred	ecity)
sior	ittendin death. ctor: Af y the fur	catio	1	on		M 1 🗆 Y	res 2□No			
Division of Vital Records,	or At after d Direct in by	Certification:	4 Homicide determine		ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or A r, State)	ural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying P	hysician: To the best o	f my knowledge, death	occurred at the tim	e, date and place,	and due to the ca	use(s) and manner a	s stated.
	n 24 h	edicai	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. License			9d. Date signed (Mon	
•			Nathan		-0-10		7044		9/5/08	,
			30. Name and address of person who	NATESAN	1415	4. DIVISION	shar	SALI	9 15 10 k	n 21804
0.22	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	r's Signature					
	Registr	ar	SEP 0	2UUb	en s	4mb				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician**  $A^{M}$ 29 2006 9:14 Anne S. Smith August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F Director 75 Jan. 12, 1931 217-28-2280 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ritema 23a or 28a-f show thermust be notified at 1 X Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 Dominion Drive Unit 1-D 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 21X Married ō Baltimore, Maryland 21215-0036 or than "natural", o 1 ☐ Yes 2 No Specify. White Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Banking . Pages 1 and 2 should be filed vitment of Health and Mental Hygie tant: If Item 27 is marked other lighty or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Loriane Sappington Viola Kate Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21702 Richard G. Smith / Husband 2402 Dominion Drive Unit 1-D Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State September permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Fairmont Cemetery 1, 2006 Libertytown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai ettending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the e 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus, Hypertension 1 Tyes 2 No. 3 Probably 4 Unknown certificate has been si irector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🔯 No 1 ☐ Yes 2 🖾 No 1 Tes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☒ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a To the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD. D-54636 September 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Montclaire Avenue Frederick, Maryland 21701 Syed Haque, M.D. 31. Date filed (Month, Day, Year) State 2006 Registrar

#### 06-06632

Please Type or Print in Black Indelible Ink

State of Maryland / Dep	partment of Health and Mental Hygien

Graham B. Smith	1-	For State	St	ate o	f Maryland			nt of Hea e of Dea		d Menta	al Hygie		a No	200	0000
Physician/		Registrar  1. Decedent's Name (First, Middle Last)  2. Date of Death										Z U I	& Time of Deat		
Medical Examine	1	Graham B			Month September					r 4, 2006					
1	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De Peninsula Regional Medical Center  Salisbury								f Death		Wicor	nty of Death nico		
Funeral	5	Social Security N	Number	6. Sex	7. A	ge (In yrs. las	st birthd			r 24Hrs. 8. I	Fore			n l	
Director		222-56-5526   1XM 2 F   36   Yrs.   Months   Days   Hours   Min.   04-08-1970   Country) NY											intry) NY		
any	_											10d Inside City Limits			
*	_	MD	isbu	oury					1 Yes 2 X						
the Maryland or 28a-f sh		0e. Street and Nu	mber					10f. Zip Code					g. Citizen of	itry?	
h the 33a or notifie		30456 Zi	on Roa	d				13. Was Dece	2180		in? ( Specify	Ves or No.	USA 14 R	ace - Ameri	can Indian, Black,
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentral Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmite event, the Medical Examiner must be notified at once. TO BE Compiled by Finneral Director	101	Marital Status     Never Marri	ed 2 X N	arried	12. Was Deceder Armed Forces	s?	5.   T				Puerto Rica			/hite, etc.	Sail Indian, Stasti
ter de	-	3 Widowed			1 Yes	2 X No	1	1 Yes	2 X No	specify:			Speci	fy: Whi	te
ours aft		15. Decedent's E	ducation (Spe	cify onl	y highest grade co	ompleted)	16a. De	ecedent's Usua	al Occupa	tion (Give k	kind of work ( use retired)	done	16b. Kind o	f Business/I	ndustry
5-0036 ed within 72 hour lygnene other than "natu the Medical Exan		Elementary/Sec			College (1-4 or	r 5+)		1d Sup	-		ŕ		Con	struct	ion
within within her the Med	Ē	10 17. Father's Name		Last)			LIE	tu sup	PELVI		's Name (Firs	st, Middle, N			1011
e filed all Hyll the control of the	٠. ا	Graham B	,		Sr.					Diana	a Mono	)			
213 ould b d Men s mar lic eve	9	19a. Informant's N	ame/Relation	ship (Ty	pe, Print )		1	Mailing Addre					ber, City or	Town, State	, Zip Code)
MD id 2 sh tith an m 27 i		Diann Sm		wife	<u> </u>	I 20h P	30	0456 Zi	on Re	oad.	Salisb Da	ury.	MD 218	804_ ion - City or	Town, State
ore, of Hea of Hea of Hea	1	20a Method of Dis	•	n 3 [	Removal from S	State C	remator	y or other plac	ce)						
Lime Page trant:		4 Donation 5	Other S	pecify		Cre	emat	ory of						ur, DE	-
Ball permit Depar Impo	- 1	21. Signature of F	. Zbo	184	RINDO			705 E	E. Ma	in St	reet,	Salis	bury,	MD 21	804
Physician	+	23a. Part I. Enter t	the disease, o	compl	ications that cause	ed the death.	Do not	enter the mod	de of dying	, such as c	ardiac or res	piratory arre	est, shock, o	r heart	Approximate Interval Between Onset and
/Medical			Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Death  Approximate Interval Between Onset and Death  Death												
- Examiner	1	or condition result	ting in death)	Ī	Oue to (or as a cor	nsequence of	"):								ļ.
4	ᇹ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
	Examine	cause. Enter Und (Disease or injury	that initiated	C.	Due to (or as a cor	nsequence of	f);		_						
uted d ansit	Ш	events resulting in	n death) Last	d.	340 10 (01 40 4 50			_	_						
to,  te be executed  ysician and burial - transit	edical	UNPENDE	D		AMENDED										
760, icate be g physic the bur	We le	IF FEMALE: 23b. Was deceder	nt pregnant in	the	23c. If yes, outo			Fetal dea	ath 3	Ectopi	c pregnancy		23d Da Mon	te of deliver th	y Day <b>Y</b> ear
Box 6876 e death certificate the attending phy ed for use as the l	sician/M	past 12 month	hs?		4 Pregnant	at time of de	ath 5				, ,				
Bo; le deat the att	Phys			nknown	9 Olivilowii		a au dein a	in the underly	underlying cause given in Part I. 23e. Did tob					contribute to	the cause of death?
i of Vital Records, P.O. Box 6876(ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phytuneral director, page 2 should be detached for use as the boundered of the control of the con	by P	Part II. Other sign	nificant conc	itions	contributing to de	eath but not re	esuitiig	in the underly	ying cause	giveriari	arr i.		s 2 🗸 No		
As, I squires aquires signaled be					<del></del>						_	24a. Was		4b. Were a	utopsy findings available
COrc	Completed									_		autopsy performed? performed? performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No			
<b>~</b> ⊢ .º ~ I		25. Was case refe	erred to medi	cal					26.Pla	ce of Death	(Check only	<u> </u>	2 140		
/ital	o Be	examiner?	2 No		lospital: 1 Inpa	atient 2	ER/Ou	itpatient 3	DOA	Other <sub>4</sub>	Nursing H	lome 5	Residence	6 Othe	er:
n of \ling Phy	-	27. Manner of De			28a. Date of (Month, Da	Injury ay,Year)	28b. 1	Time of Injury		jury at Wor	_ [	d. Describe	how injury o	ccurred	
	atio	1 ✓ Natural 2 Accident		nding restigati	on			-	_	Yes 2		f Location (	Street and h	lumber or P	ural Poute Number City
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be determined (Specify)  Suicide 6 Could not be determined (Specify)													
2 92 Certifier 2 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2											anner as sta	irted.			
To the Hos within 24 h To the Fur	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo														
	29b. Signature and title of certifier						O.C.M.E.					September 5			
(02)		30 Name and as	dress of pers	J	completed cause	of death (Iten	n 23a)								
40		Ling Li, M	D Assis	tant N	ledical Exami	ner 111	Peni	n Street, B	altimore	e, MD 21	201				
Sta Regist			on'S EP Ye	77	2006 32. R	strar's Signat	ure	Some	20						
DHMH 17 Rev 1/20							OR	RIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 30072 Stata Registrar#5 per FH/wichd/9-14-06/dls Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Jacqueline C. Sheppard sept. 2006 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner lisbury Rehaba Nursing Ctr icomico  $\geq \alpha$ 5. Social Security Number 1645 If Under 1 Year | If Under 24 Hr Months Days Hours | Min 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 Ø F Director 222-50-6148 Jan 13, 1968 DE Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumetic event, the Medical Examiner quest be notified at 1X Yes 2 No MD Wicomico Salisbury Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 714 Dennis St. or Items 23e 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. I ☐ Yes 2 ☑No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 Widowed 4 Divorced Year or Dates: "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Housing Manager Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Be Walter Johnson, Sr. Martha Lee Teagle 19a. Informant's Name/Relationship (Type, Print) Daughters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9650 Covered Wagon Dr., Apt. J, Laurel, MD 20723 If item 27 Candace & Rochelle Winder/ Pages 1 and other t altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 □Donation 5 □ Other (Specify) Salisbury, MD Green Acres Mem Park 9/9/2006 22. Name and Address of Facility
Lewis N. Watson Funeral Home 21. Signature of Funeral Service Licensee Mara 4 Walson 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical the phys IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) o 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 10 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No of Vital 1 Yes 2 1 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 □ Yes 2 No 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; or Attending 1 A Hatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No after death investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Hospitel Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifler

31. Date filed (Month Day

Registrar DHMH 17 Rev 1/2001 bins, M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

aco Civic Ave.

29d. Date signed (Month, Day, Year)

Salisbury, MDARY

			For State Registrar		State of	Marylan		artment of H		d Mental H		2006	30073
	Physici /Medic		Decedent's Name (     George	First, Middle,	<sub>Last)</sub> David	Snad	er			2. Date of D Month	Day	Year 2000	3. Time of Death
	Examin		4a. Facility Name (If n Solisbu 5. Social Security Nun	ry Re	habaN			4b. City, Town, or South	SOUY	Death	4c. 0	Dounty of Death	nico
	Funeral Director		216-09-360 Usual Residence of D	67	1 <b>⊠</b> M 2□F	96	Yrs.	Months Days		Min. (Month, D. 10/3/.	Pay, Year)	Mary	lace (State or Foreign try) Land
	a-f show	ctor	10a. State 1	Ob. County Wicor	nico		, Town or Lo lisbur					1	0d. Inside City Limits 1 Yes X No
,	death with the ms 23a or 28a	al Dire	10e. Street and Numb		Circle			10f. Zip Code 21804	4			en of What Coun JSA	itry?
de la	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Itams 23a or 28a-1 show any injury or other treumatic event, the Medical Exam as trivial to a difficular angle.	by Funeral Director	11. Marital Status 1  Never Married 3  Widowed 4		12. Was Deced Armed Ford  1  Yes 2 If Yes, Give Year or Dat	es? MNo		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 1 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: wh	
Sha 21215-0	within 72 ho ene. then "netur he Medicel	Completed			Education grade completed) College (1-	4 or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired linator	ation during most of d)	f working	Amer		dustry tomobile -Road Svcs.
land 2	uld be filed fental Hygi rked other tic event, I	To Be Co	17. Father's Name (Fi						_	Name (First, Middl Cence Nusl	e, Maiden S		
Mary	ind 2 should alth and Men (27 is marke) is treumatic		19a. Informant's Nam Vivian Si					•		or Rural Route Num Le, Salisi	-		
Sec.	Pages 1 a nent of He int: If item iry or othe		20a. Method of Dispo 1 ☐ Burial 2 🛣 4 ☐ Donation 5	Cremation 3	3 □Removal from S	late		sition (Name of natory or other place y Cremato	1	Date /4/06		ation - City or To	
Balti	permit. Departn Importe any inju		21. Signature of Fund	Rhh	wer (F)	P	5	01 Snow I	Hill Ro	d., Salis	oury,	ional As MD 2180	sociation 4
68760,	Physician and /Medical Examiner burial-transit sthe burial-transit	edicai Examiner	23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)  Sequentially list cond if any, leading to immease. Enter Underly Cause (Disease or in that initiated events resulting in death) La	inal litions, nediate ving jury	a. Due to (c)	r as a consequence	uence of):	er the mode of dyin	7	rdiac or respiratory	le le	1-3	Approximate Interval Between Onset and Death
.O. Box (	The law requires that the death certificate tte has been signed by the attending physbage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?		th 2 ☐ Feta nt at time of d	Ideath 3	]Ectopic pregnancy ] Other (specify)	,		23	3d. Date of delive Month	ery Day Year
<b>a</b>	uires that the de signed by the a Id be detached f	þ	Part II. Other signific	ant condition	s contributing to dea	ath but not res	ulting in the u	nderlying cause giv	en in Part I.			e contribute to th	ne cause of death?
Recor		Completed									opsy formed?	prior to cor death?	psy findings available inpletion of cause of
of Vita	Physician: this certific al director,	To Be	25. Was case referre examiner? 1 Yes 2 2 7. Manner of Death	6	28a. Date of	Injury	ER/Outpatier		er: 4 Hursi	Death (Check only ng Home 5 Res	sidence 6	Other (Specify	y)
Division of Vital Records,	i giệ c	Certification;	1 ☑Matural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending investiga 6 Could no determin	ot be 28e. Place	of Injury - At hog, etc. (Specif	Injury ome, farm, str		Yes 2 No	28f. Location	(Street and own, State)	Number or Rura	I Route Number,
	e Hospital 24 hours a le Funerel l letely filled	edical C	29a. Certifier 1 (Check only 2 one)	Medical E	Physician: To the l xaminer: On the ba and mann	sis of examina	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	me, date and popinion, death	place, and due to the	e cause(s) a e, date and p	and manner as st place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and til	tle of certifier	Min			29c. Licens	e number	48	29d. Date	signed (Month,	Day, Year)
	Sa		30. Name and address	T.H.F	lobins,	M.D.	200	Civic	Ave.	Salisl	oun	I,MD	21804
	Sta Regist	rar	31. Date filed (Month	EP 0 6		gistrar's Signa	ture	noule					

#### Please Type or Print in Black Indelible Ink

tin Leo Shult		1- For State Registrar	St	ate of Man			nent of cate of		and	Menta	и нуд		Reg. No.	200	16 3	3007
Physicia	an/	1. Decedent's Nam										Date of De Month August 3		Year	3. Time of I	
dical Exami		MARTIN 4a. Facility Name	I LEO S		I number)		4	b. City, Towr	n, or Lo	cation of [		August 3		ounty of Dea		
				ack Dog Alley				Easton					Tal	bot		
Funeral		5. Social Security	Number	6. Sex	7. Age (In	yrs. last b	oirthday)	If Under 1	Year Days	If Under 2	24Hrs. 8		irth(MM/DE	Fore	irthplace (Stat ign	e or
Director		212-84-7	7869	1 <b>X</b> M 2	F 44	·	Yrs.	MONTHS	Days	riodis	Will J.	MAR !	5, 196	<b>52</b> C	ountry) MAI	RYLAND
á	- 1	Usual Residence of 10a State	of Decedent 10b. County		10c.	City, Tow	vn or Location	on							10d. Inside	City Limits
id how a	_	MD	Т	ALBOT	ļ	NEW	СОМВ								1 Yes	2 <b>X</b> No
larylar 28a-f s at on	Director	10e Street and Nu	L			-		10f. Zip Co	de				10g. Citizer	of What Co	untry?	
ith the Maryland 23a or 28a-f show any		25905 V	VALNUT	ST.						1653				' USA		
eath with the items 23a	Funeral	11. Marital Status  1 Never Marr	ied 2 X		Decedent Ever d Forces?	r in U.S.		Decedent of es, specify C					0- 14	Race - Ame White, etc.	rican Indian, I	Black,
ter dea		3 Widowed		1 Yes, Give or Dates:		No	1	Yes 2 X	No s	specify:			Sp	ecify.WHI	re	
ours af atural xamin	d by	15. Decedent's E	ducation (Spe	or Dates: Dify only highest of	grade complet	ed) 16a	a. Decedent	's Usual Occ						d of Business		
136 hin 72 hou e than "nati edical Exa	lete	Elementary/Sec	condary (0-12)	Colleg	e (1-4 or 5+)		OWNI	`	y 1110. D	01101 43	30 1011100	7		LOOR SA	ANDING	
	Completed	12 17 Father's Name	First, Middle,				OWINI		18	.Mother's	Name (F	irst, Middle	Maiden Su		MDING	
21215-00	Be	JOHN W	ILLIAM	SCHULTZ								URCEK				
	유	19a. Informant's N				3 1		Address (S						or Town, Stat	e, Zip Code)	9
Para are		20a. Method of Dis		LIZ/ WIFI			e of Disposi	tion (Name o				ate			r Town, State	
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr			X Cremation		al from State		natory or oth		АТТ	ON C	TR 9.	/2/20	06 S'	revens'	VILLE,	MD
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 21 Signature of F	uneral Service	Licensee			22. N	ame and Ado	dress o	f Facility						
	4	Joseph		Istrowik			200	D S. B	ARR	ISON	ST	EASTO	N MD	21601	L HOME	PA
Physician /Medical		23a. Part I. Enter t failure. List o	nly one cause	on each line.		death. Do	not enter th	e mode or a	ying, su	ich as can	giac of Te	espiratory a	irest, shock	, or near	Between	ate Interval Onset and eath
Examiner		Immediate Cause or condition result			injuries as a conseque	ence of):			_	_	_				-	
		Sequentially list c		b								_			_	
	nine	if any, leading to i cause. Enter Und (Disease of injury	derlying Cause	c.	as a conseque	ence or).										
ed nsit	Examiner	events resulting in		,	as a conseque	ence of):										
0, be executed sician and burial - transit	Medical	UNPENDE	D	d AMENDE	ED .										<del>                                     </del>	
760, cate be ex physician he burial		IF FEMALE:			es, outcome o	f pregnan	су							Date of delive	ry	
Sox 6876 leath certificate e attending phy for use as the b	cian/	23b Was deceden past 12 month			ve birth egnant at time	of death		al death ner (Specify,	3	Ectopic p	oregnanc	У	M	onth	Day	Year
Box e death c the atten ed for us	Physician/I	1 Yes 2	No 9 Un	known 9 UI	nknown		J OII	iei (Opeary)		L'OUNCE D			1			
b.O. that the red by 1 detache	by P	Part II. Other sign	nificant condit	ions contributir	ng to death bu	t not resul	Iting in the u	nderlying ca	use giv	en in Part	1.				o the cause of obably 4	
of Vital Records, P.O. ng Physician: The law requires that the three this certificate has been signed by neral director, page 2 should be detac	ted l										_	24a. Wa			autopsy finding	
COFC law re has be	Completed											per	opsy formed?	death?		_
tal Recian; The		25. Was case refe	erred to medica	1				26.1	Place o	f Death (C	heck onl		2 No	1 🗸	Yes 2	No
Vita hysician this cer al directe	o Be	examiner?	2 No	Hospital: 1	Inpatient	2 ER	R/Outpatient		10	thor:		Home 5	Residenc	e 6 🗸 Oth	er: Scene	
of ing Ph		27. Manner of Dea	ath	28a D	ate of Injury lonth, Day Year) 30, 2006	1	b. Time of Ir		_	at Work?	ים!		e how injury orcvcle a	occurred auto collisi	on	
Sion Mtendi death. ctor:	atio	1 Natural 2 Accident	5 Pen-	stigation			003 hrs			s 2 🗸 N	No					
Division tal or Attendir rs after death. al Director: A	Certification:	3 Suicide	dete	id not be	Place of Injury				rice bui	iaing, etc.		or Town,	State)		Rural Route Ni Alley, East	
Hospit Hospit 24 hour Funera		4 Homicide 29a Certifier 1		hysician: To the					ne, date	and place						on, me
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2		miner: On the ba and mann	sis of examina			ion, in my op	oinion, o	death occu			e and place	e, and due to	the cause(s)	
->-0	ž	29b. Signature an	nd title of certifi		1					number					lonth, Day, Yea	ar)
		1/hm	a Dia	sell, il	1.6.	n /ltom 22:	0)		).C.M	· <b>L</b> ·			^ugu	st 31, 200	·	
		30. Name and add Melissa Br	assell, MD	Assistant	Medical Ex			enn Stree	et, Ba	ltimore,	MD 2	1201				
S Regis	tate trar		onth, Day, Year)	ŽUUD 3	Registrar's	Signature	A son	No.								
-	_															

State of Maryland / Department of Health and Mental Hygiene

- State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2006 Physician 1, 10:45 AM D. Sept. Henry Singman /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hebrew Home of Greater Washington Rockville Montgomery Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** 1**∑** M 2□ F Washington, DC Director 577-16-7718 Usual Residence of Decedent death with the Maryland injury or other treumatic event, the Mudical Exacultar must be notified at 8. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15101 Interlachen Dr. #424 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status e filed within 72 hours after on Hygiene.

Al Hygiene. 1 X Yes 2 □ No II Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hy tant: If Item 27 is marked oth Be Samuel Singman Anna Dick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elease Bruner - friend 12101 Little Creek Drive Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 XRemoval from State permit. Page Department of Important: If King David Memorial 9-3-06 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name Danzansky Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Licensee K 1170 Rockville Pike Rockville, MD 20052 Approximate Interval Between Onset and Death 23a. Part1. Enter the dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lung disease or condition resulting in death) Cancer /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if the leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien thed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes 2₽No To the Hospitel or Attanding Physician: 24 hours after death.
• Funeral Director: After this certific letely filled in by the Juneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 3 DOA 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner el Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dust to the nause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 ia Cartifier edical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 1 2006 12 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) holkville Maryland 2015 2 3. Willer, ZVA 6121 Mentrer 32 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 06 State 2006 Registrar

			1 - For State Registrar	State o	f Marylai	nd / Depa	artmen rtificat			and M		giene	201	16	3007	6
	Physici		Decedent's Name (First, Middle,     Petra Simon	Last)							2. Date of De Month Septem	Day	32	rear DO	3. Time of Death 0254	М
ı	/Medic Examin		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City.	Town, or	Location o		Septem	4c.	County of	Death		
	Funeral Director		5. Social Security Number 217–26–3395	5. Sex 1 □ M 2 🗓 F	7. Age (In yrs 95	. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da May 19	iy, Year)		Coun	lace (State or Forei try) to Rico	gn
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Carol:	ine	,	ity, Town or Lo								1	0d. Inside City Limit	
	a with the	Funeral Director	10e. Street and Number 17040 Melville I				10f. Zip	Code 2164	0			10g. Citi	izen of Wh	at Coun	try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28s-f show styling or other treumatic event, the Mudical Exeminer must be notified at ance.	ğ	11. Marital Status  1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	rces? 2 (2)No re		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:		ecify Yes or No Rican, etc.)	)-	14. Race -	White,		
Baltimore, Maryland 21215-0036	within 72 ho iene. then "natur ite wedicel	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 05	Education grade completed)  College (1	-4or 5+)		dent's Usua kind of wo DO NOT us emake	rk done d se retired)	ition luring most	of worki	ng	differential designation of the second secon	nd of Busi		lustry	
yland	should be filed ind Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Launknown	ast)					18. Mothe Salon		(First, Middle					
, Mar	and 2 shi selth and n 27 ie m		19a. Informant's Name/Relationshi Debra Ann Simon,			aw 170	40 Me	lvi1	le Ro		l Route Numb lenders					
more	Pages 14 nent of He ant: if item arry or oth		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Spe		State	Place of Dispo cemetery, crer eensbo			1		7 2006		eensb	•		
Balt	permit. Page Depertment of important: if eny injury or once.		21. Signature of Funeral Service Li	Censee	el-	F	leeg1	e an	s of Facility d Hell Gree	fent	ein Fu oro, Ma	nera rvla	1 Hon	ne, ]	PA	
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	omplications that conly one cause on e	ach line.	th. Do not ent	er the mod	le of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death	
	/Medical Examiner	ner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (	or as a conse	quence of):										
8760,	ate be executed thysicien and the burial-transit	cai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse	quence of):										
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		irth 2□Fet ant at time of	al death 3	Ectopic pr Other (sp						23d. Date Month		ry Day Year	_
٥.	w requires thet been signed b should be deta	þ	Part II. Dther significant condition  Depremental	s contributing to de	eath but not re	sulting in the u	nderlying o	ause give	n in Part I.			obacco u Yes 2[			e cause of death?	m
Division of Vital Records,	The law re ete has bee page 2 sho	Completed	acute !	ciency	fail	ve '							de:	ath?	osy findings availab npletion of cause of 2 No	le
Vita	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:	( of	3500		Othe	-		(Check only o		- 50.	10		
ion of		ation: To	27. Manper of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of (Mont	npatient 2 [ of Injury h, Day Year)	28b. Time of Injury		8c. Injury Work	4 🗀 1901	2	ne 5 Resi 28d. Describe				)	
Divis	To the Hospital or Attending Phwithin 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could no determin	ad 286. Place	of Injury - At h	nome, farm, str	eet, factory	, office		2	28f. Location ( City or To			or Rura	Route Number,	
	To the Hospita within 24 hours To the Funeral completely filled	edicai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the ba and mann	asis of examin	owledge, death ation and/or in-	occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s) date and	and mann place, an	ner as sta d due to	ated. the cause(s)	
	To the Complex	Σ	29b. Signature and title of certifier	1.1	mit	- w	290	. License	number 40	43		P.	e signed (			
			30. Name and address of person w	-	e of death (Ite		Print)	shi?	reston	S+.	Eas.	fon.	w	2	2006	
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. 6	egistrar's Sign		melle	p	1'			· -1.				_

Simon, Petra

		-	State of Maryland / Depart	ment of Health and Me ficate of Death	ntal Hygiene	2006 30077
	ALC. TO		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physici /Medic		Betty Rose Sutphin	S	eptember	5,2006 3:35A <sup>M</sup>
	Examin		Tall acting trains (it that it of the state	b. City, Town, or Location of Death	4c.	County of Death
9.45				La Plata If Under 1 Year   If Under 24 Hrs.   8	B. Date of Birth	Charles
	Funeral Director			Months Days Hours Min.	JST 13, 1	9. Birthplace (State or Foreign Country) NC
100			Usual Residence of Decedent			
	ahow	_	10a. State 10b. County 10c. City, Town or Locati			10d. Inside City Limits 1
	88-1	ecto	MD Charles La Pla	ata 10f. Zip Code	10g. Cit	izen of What Country?
	with t	D	10e. Street and Number 10200 La Plata Road	20646		USA
	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "naturel", or fleme 23e or 28e-f ahow event, the Madical Examinar must be mailfied at	Funeral Director		s Decedent of Hispanic Origin? (Species, specify Cuban, Mexican, Puerto Ri	rty Yes or No-	14. Race - American Indian, Black, White, etc.
٥	or ite	Fur	1 Never Married 2 Married 1 Yes 2 No	Yes ZE No Specify:	ioditi, oto./	Specify: American
12-NU36	72 hours after natural', or ite dical Examina	d by	3 ⚠ Widowed 4 ☐ Divorced Year or Dates:	nt's Usual Occupation	16b K	Indian ind of Business/Industry
γ	n 72 in 72 in at	ojete	(Specify only highest grade completed) (Give kin	nd of work done during most of working ONOT use retired)	3	and of Datamoodily
7 7	within jiene r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		Home
and	al Hygi I other	Bec	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Locklea:	
Z		ဥ	Ralph Brooks			or Town, State, Zip Code) 20646
<u>a</u>	12 sh h and 7 is m traum		1,12,1	Catalpa Drive,		
ص ر	ges 1 and 2 should t of Health and Mer if item 27 is marke or other traumatic		20h Plans of Dispositi	ion (Name of Da	te 20c l	ocation - City or Town, State
ē	Pages nent of int: If it iry or o		Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	tory or other place) Veterans 9/11	/06 Che	ltenham,MD
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or oti		21. Signature of Funeral Service Licensee , MOO945 22. A	REHART-ECHOLS	FUNERAL	HOME, P.A.
n	88 5 8					Plata, MD 20646 Approximate
	Physician Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Drumon		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	7,000		
ì	LXB/IIIIei	70	Sequentially list conditions, b. Due to (or as a consequence of):			
	uted d ansit	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
o,	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760	ate be hysici the bu	dical	d			
9		/Mec	IF FEMALE: 23c, If yes, outcome of pregnancy			23d. Date of delivery
Box	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 E	ctopic pregnancy Other (specify)		Month Day Year
o.	0 0 0	hysi	9 Unknown			
Division of Vital Records, P	% <u>7</u>	þ	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?  No 3 Probably 4 Junknown
00	s been sign	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	The lav	E O			performed? 1 ☐ Yes 2 ☐ N	death?
<u>i</u>		Be	25. Was case referred to medical axaminer?	26. Place of Death		
<u>&gt;</u>		2	1 ☐ Yes 2♣ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		ne 5 Residence	
UC.	ding F h. After funer	tion	tXNatural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at	od. Doodilbo nov mje	ny 5550.154
/isic	or Attending Phater death. Director: After the	Certification:	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, stree	et, factory, office 2	8f. Location (Street a City or Town, Star	and Number or Rural Route Number,
ă	al or safter safter al Dire	Certi	4 Homicide determined building, etc. (Specify)		City of Town, Stat	6)
	To the Hospital or Attani within 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of more contained in the property of	occurred at the time, date and place, a stigation, in my opinion, death occurre	and due to the cause(s ad at the time, date an	s) and manner as stated. nd place, and due to the cause(s)
_	To the I	Me	29b. Signature and title of)certifier	29c. License number	29d. D.	atersigned (Month, Day, Year)
			7.10km MD	055455	19/	6/06
(	0 ~		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri		101 0	on Consider MD
-0	D) /	212	Fatima Hussein, M.D. 5625 Allent  31. Date filed (Month, Day, Year)  32. Positrar's Signature	own Rd. Suite	IUI, Cam	h shrings'mn
A. 1880	Regis	tate trar	SEP 0 8 2006 Seem &	and a		

State of Maryland / Department of Health and Mental Hygiene 30078 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 31 Eugene Russell Smith 06 8:40 p Aug /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery
9. Birthplace (State or Foreign Country)
West Virginia Takoma Park
Under 1 Year | If Under 24 Hrs. Washington Adventist Hospital 8. Date of Birth (Month, Day, Year) May 29, 1917 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2□ F Days 236-30-3302 89 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the them 27 is marked other then "naturel", or items 23e or 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director Hyattsville 10f. Zip Code MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 5606 Hamilton Manor Dr 20782 U.S.A. Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify Specify: β 3.☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th private Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Smith Clarkey Shanklin Medley 0 6910 Mailing Address (Street and Number of Rural Route Number City of Town, State, Zip Code)
Avon St. Seat Pleasant, MD 20743 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health an Importent: If item 27 Is any injury or other treu once. Rebecca Dugar/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln 10-12-06 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ft. Lincoln F.H. 3401 Bladensburg Rd. Brentwood, MD 207 enter the mode of dying, such as Cardiac or respiratory arrest, pproximate Interval Between Onset and Death (3a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EUMONIA Physician /Medical Due to (or as a consequence of): RESPIRATORY FAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine TATIC CARCINOMA OF PROSTATE burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Winknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 No 1 Yes 2 🙀 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ⊋ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 52855 8/31/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20782 7600 Carroll Chandra S. Korapati Takoma Park, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 9 8 2006 Registrar

			1 - For Amend item#23a,2	State of Mar 8d, perME,g8	ryland / D 60 10/6/0	epartmen Certificati	t of He	ealth a Death	and M	lental Hy	giene Reg. No. 2 (	006	30079
	Physici /Medio		Decedent's Name (First, Middle, Last)     REGINALD			EVENSO	N			2. Date of De Month	Day 23, 20	Year 06	3. Time of Death 16:57
	Examir	ner	4a. Facility Name (If not institution, give s Univ. of Marylar	nd Medica		t Bal	timo					y of Death	
	Funeral Director		5. Social Security Number 6. Sex 218-50-1816	M 2FF	(In yrs. last birt	rs. If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Aug 22	th ly. Year) , 1949	9. Birth Cou	place (State or Foreign ntry) MD
	Maryland f show	tor	10a. State 10b. County MD Wicomico		10c. City, Town								10d. Inside City Limits 1 ☐Wes 2 ☐ No
	with the	Funeral Director	10e. Street and Number			10f. Zip					10g. Citizen of	What Cou	ntry?
	eath v	erai	806 Mohawk Avenue	2. Was Decedent Ev	er in U.S.		801	nanic Orio	nin? (Sne	ecity Vac or No	US 14 Ba		can Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show ship injury or other treumetic event, The Medical Exacting runst be notified at ances.	by	1 ☐ Never Married 2⊠ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		13. Was Deced		Specify:	, Puerto	Rican, etc.)		ick, White,	etc.
215-0	nin 72 ho In "natur Medical I	Completed	15. Decedent's Educ (Specify only highest grade			Decedent's Usua (Give kind of wor life. DO NOT us	rk doné du	uring most	of worki	ng	16b. Kind of E	Business/Ir	ndustry
2	filed with Hygiene other the	Com	12	College (1-401 5+)	<u> </u>	Don	nesti	.C			v	ariou	ıs
Maryland 21215-0036	should be fill and Mental H, marked oth umetic even	To Be	17. Father's Name (First, Middle, Last)  Milton Lee Stevens	on						(First, Middle, e Bivan	Maiden Sumai S	me)	
Mar	12 sho h and 7 is mu treum		19a. Informant's Name/Relationship (Typ			Mailing Address							Code)
altimore, l	Pages 1 and nent of Health int: If Item 27 iry or other to		Fanny Mae Stevenso  20a. Method of Disposition  1X Burial 2 Cremation 3 Re		20b. Place of cemeters	6 Mohawk Disposition (Nam r, crematory or of rn Shore	ne of ther place	1		LSbury,	MD 218		own, State
altin	permit. Pa Departmer Importent any injury once.		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	B	Veter	ans Ceme	etery d Address	of Facility	V	/2006	Hurlo	ck, M	ID
<u> </u>	90 5 5 9		Jalara All	alson			est R	d., S	Salis	sbury,	MD 2180	1	
	Physician		23a. Part <sup>1</sup> . Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.  Cardio			, ,		cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner			Subarac						.11	1/1		
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consulpiance o	n:			_	116	L EXAMINER		
8760,	icate be executed physician and s the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a d	consequence o	f):		0	E LAPPE	SEDIO.			
687	ificate g phys as the	edical	d					PTIFICA	7				
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	tc. If yes, outcome of 1 Live birth 2 4 Pregnant at tin 9 Unknown	Fetal death	3 ☐Ectopic pro	egnancy		v			ate of delive onth	ery Day Year
ecords, P.	The law requires that the te has been signed by thogge 2 should be detached.	by	Part II. Other significant conditions con	ributing to death but	not resulting in	the underlying ca	iuse giver	n in Part I.					he cause of death?
$\mathbf{x}$	The law recate has bee page 2 sho	Completed									rmed?	death?	psy findings available impletion of cause of
_		a	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	-23	1 □ Yes	2 No
of <	Physical this ceral direct	To B	X 198 2 INO	ospital: 1 Xnpatient		patient 3 DO	Annual Control	4 🗀 1401			lence 6 Oth		iy)
00	ding f h. After funer	tion:	27. Manner of Death  1 Natural 5 Pending  Investigation	28a. Date of Injury (Month, Day Y Aug 23,		me of 29 jury ):40 м	Bc. Injury a Work?	at ? es 2 ⊟ N	-		in he		fell off
Division		Certification:	Accident investigation  3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, fan					City or Tow	treet and Numb		al Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	cian: To the best of re: On the basis of each manner state	xamination and	death occurred a for investigation,	at the time in my opi	e, date and nion, death	d place, a	Salis	Ouly,	Md anner as s	lated. the cause(s)
	To the Ho within 24. To the Fu completel	Me	29b. Signature and title of pertifier			29c.	License	number			29d. Date signe	ed (Month,	Day, Year)
	2/6		1/4 Unt H MD	aplated agues of deep	th (Itom 22a) (I		7753	3			August	28,	2006
1	10,71			ta 22 S.	Green		et,	Balt	timo	re, Ma	arylan	d 21	201
•	Sta Registr		AUG 3 1 20	32. Popistrar's		Spertle	,						

			For	State of Maryla				-	_	<b></b>
			1 - State Registrar			ertificate of			eg. No. 20	06 30081
	Physici	an	Decedent's Name (First, Middle, La.	st)				2. Date of Deat Month	Day Ye	3. Time of Death
	/Medic	cal	Ina Jones S 4a. Facility Name (If not institution, giv			4h Cihi Taura	or Location of Death	Augus	4c. County of E	
	Examin	ier		hab & Nurs	inch	So I	15bury			omico
- <u>*</u>	Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last irthday	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birth (Month, Day,	9.	Birthplace (State or Foreign Country)
en. P	Director		216-18-8653	□M 2対F 9	4 Yrs.	Wioriti's Day's	Tiours With.	May 2		Maryland
land	MO MI		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
Many	a-f sh iffed	tor	MD Somers	et	Prince	ss Anne				1 ☐ Yes 2 🔀 No
death with the Maryland	ntal Hygiene. ed other than "natural", or Itams 23e or 28e-f show event, Ita Medical Examinat must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of Wha	t Country?
ath w	8 238	rai	28768 Larry Lankf			21853			USA	
	Itam	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No	1 U.S.   13.	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
DCOU	el', or Exam	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	Black
d Z I Z I 3-0030 filed within 72 hours after	natur	Completed	15. Decedent's Ed (Specify only highest gra	Jucation (de completed)	16a. Dece (Giv	edent's Usual Occu e kind of work done	pation during most of work	ang	16b. Kind of Busin	ess/Industry
Aithin	than a Mu	mpi	Elementary/Secondary (0-12) 6th	College (1-4or 5+)		DO NOT use retire borer	ed)		Domesti	C
E P	Hygie other ent, tt	e Co	17. Father's Name (First, Middle, Last)		Па	DOLCI	18. Mother's Nam	e (First, Middle, N	Maiden Sumame)	
	marked c	To Be	John H. Nutter				Laura F	rances W	illiams	
laryia 2 should	and h		19a. Informant's Name/Relationship (	** *			t and Number or Rui			
and ₹	of Health and Meritem 27 is marke		John H. Jones/Son							Anne, MD 21853
Pages	nt of h		20a. Method of Disposition  1 Burial 2 Cremation 3	Tuestional trotti State		osition (Name of ematory or other pla	1		20c. Location - City	
E &	Department of Important: If I any injury or once.		4 Donation 5 Dother (Specification of Specification of S	THE		hurch Cem. 22. Name and Addre	Sept. 121 sss of Facility			ne, Maryland
	Impo eny ir		Loretta B.	falley			morial Cha	_		MD 21801
	- Fig.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	orcations that caused the de	eath. Do not er	nter the mode of dyi	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition resulting in death)	a Condio	zny1	love				Onset and Death
	Medical kaminer		resulting in dealth)	Due to (or as a cons	equence of)	14	0 _	1.0		
	莱	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):	- 21	216	a day &		grans
cuted	od ransit	Examiner	that initiated events	c. Per	en and	a	· ·			years
/ OU, te be executed	nysicien and he burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					1
	physic the b	dicai		d						1
The law requires that the death certifical	ettending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. Date of	delivery
death	e ette	icia	in the past 12 months?	1 Live birth 2 ☐ Fo 4 ☐ Pregnant at time o		□Ectopic pregnanc □ Other <i>(specify)</i> _	:y		Month	Day Year
a the	signed by the e Id be detached f	Phys	9 🗆 Unknown	9□ Unknown				_		
ies th	signed be de	þ	Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cause gr	ven in Part I.			te to the cause of death?
w requires t	been si should	ompleted								
De lav	s hes	mp						24a. Was ar autopsy perform	prior	e autopsy findings available to completion of cause of h?
	tificet for, pa	C	25. Was case referred to medical				26 Place of Deat	1 Yes 2		Yes 2□ No
ysici	this certificete hes al director, page 2	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ott	hor		nce 6 Other (S	Specify)
ding P	ofter thunera		27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time ( Injury	Wo	rk?	28d. Describe ho	w injury occurred	
tend T	death	Certification:	2 Accident investigation 3 Suicide 6 Could not b	9 00 01	homo form o		]Yes 2 □No	29f Lanation (Ctr	root and Alumbara	- O 1 Oo 1 Oo 1
or A	after Direct	ertif	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	icity)	reet, factory, office		City or Town		r Rural Route Number,
spite	hours inerel y filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge, dea	th occurred at the ti	ime, date and place,	and due to the ca	use(s) and manne	r as stated.
To the Hospitel or Attending Physician:	within 24 hours after death.  To the Funerel Director: After thi completely filled in by the funeral	Medical	onej	niner: On the basis of examinand manner stated.	ination and/or ii			red at the time, da	te and place, and	due to the cause(s)
P	To	2	29b. Signature and title of certifier			29c. Licens	se number	0 29	d. Date signed (M	onth, Day, Year)
	B		30. Name and address of person who	annelstad spuss of death (I	lom 22a) (Tugo	Print)	2/34	7 1	130/66	/
	40		William H.	Robins, m.	<u> </u>	00 C	vic Aro	Salis	Spura	MD 21804
W. Sa	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig			-1/4		31	7

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** AILEEN LITTLETON THOMPSON 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hiermica 39488414 KEGIONAL PININSULM CENTOL Months Days Hours Min. 8. Date of Birth Months Days Hours Min. 10705/1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 1 ☐ M 2 😿 F 213-18-4922 84 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State •how r than "natural", or iteme 23a or 28a-f ehor the Medical Examinar must be notified at TYPYes 2 No Director MD Worcester Pocomoke City 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 21851 USA 610 Walnut Street within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes ZNo If Yes, Give Year or Dates: 1 Never Married 20 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) other than College (1-4or 5+) Retail Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: if item 27 is marked other 17. Father's Name (First, Middle, Last) Ernest Nutter Bertha Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Owen C. Thompson/ Husband 610 Walnut Street, Pocomoke City, MD 21851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crem. 09/07/06 Salisbury, MD 21. Signature of Fune 1 Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A. Muc 103 Linden Ave., Pocomoke City, MD 21851 eun 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dileale Artes Physician Coronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consecuence of) Examine burial-transit and Due to (or as a consequence of): attending physicien for use as the buria Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown as been si 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ormed? 2XΩNo 1 Yes Division of Vital 25. Was case referred to medical examiner? completely filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? al or Attending Ph s after death. ii Director: After th 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funerai C Certifying Physician: To the best of my knowledge death occurred at the small data and place, and due to the nause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier september 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AgaINAL 145 E. CARROLL BA 5 KAMESH 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 8 2006 Registrar

			For State Registrar	State	of Mar	yland / [	epa <i>Cer</i>	rtment of tificate of	Health Deat	and M h	lental Hyg R	iene <sub>eg. No.</sub> 2	006	30082
	Discouries!		1. Decedent's Name (First, Midd	le, Last)							2. Date of Deal	th Day	Year	3. Time of Death
	Physici /Medio		George Albe	rt Totte	า						Ausual		2006	1904 M
	Examir	er	4a. Facility Name (If not institution PENINSULA Region)	-		CENT	实	4b. City, Town,		n of Death	V	4c. Cou	Inty of Death	ios
	Funeral Director		5. Social Security Number 224-74-1609	6. Sex 1⊠M 2□F	7. Age (	In yrs. last biri	thday)_ Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birth (Month, Day) July 16,	Year)	Coui	place (State or Foreign pinty) jinia
	P		Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Town		ation						IOd. Inside City Limits
	ehov	'n	MD Wicon		'			ation						1 ☐ Yes 2½ No
	28a-f	Director	10e. Street and Number			Delma	ar	10f. Zip Code				On Citizen	of What Cour	
	3a or		9544 Ocean High	าพลง				218	75				or titlet ood	
	me 2;	Funerai	11. Marital Status	12. Was De		er in U.S.	13. W	as Decedent of	Hispanic (	Origin? (Spi	ecify Yes or No-		Race - Americ	
336	e filed within 72 hours after deeth with the Maryland at Hygiene. I other than "neturel", or Iteme 23s or 28s-1 show vent, Ita Medical Examinat must be notified at	by Fur	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1√∑Yes	Forces? s 2 ☐ No Sive Dates: 1	972 <b>–</b> 73		Yes, specify Cul ☐ Yes 2⊠ No			Rican, etc.)		Black, White, ecify: Blac	
15-0036	"neturel", edical Era			nt's Education			Deced	ent's Usual Occu	pation		V-	16b. Kind o	f Business/In	
7	thin 7	Completed	(Specify only nigne Elementary/Secondary (0-12)	st grade complete	(1-4or 5+)		life. D	ind of work done O NOT use retire	e during m ed)	ost of work	ing			- 7
7	ed wil	Son	10th					Labore					-emplo	yea
Maryland	ntai H ed oth ed oth	Be	17. Father's Name (First, Middle,	Last)							e (First, Middle, I	Maiden Sun	name)	
چ	nouid be d Mental narked o natic eve	<sup>L</sup>	Robert Jordan	tie (Tiese Orien)		101	B.4 - 717				a Lewis		0	0.11
<u>s</u>	d 2 sho th and 17 le m traum		Jean B. Totte					,			Delmar,			
	s 1 and 2 should f Heelth and Mer Item 27 le marke other traumatic		20a. Method of Disposition	II/ WIIC		20b. Place of	Dispos	ition (Name of					on - City or To	
ē			1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5		n State		-	atory or other pla	ace) !	Sont	6 2006	Salis	hurv.	Maryland
Baltimore,	permit. Page Department of Important: If any injury or ance.	1	21. Signature of Funeral Service			Salisbu		rematory Name and Addr	ess of Fac		3 Jersey 1		241,	
ñ	Per Per Per Per Per Per Per Per Per Per		Louter	D. Joll	up		Jo	lley Mer	noria	1 Cha	pel - Sa	alisbu	ary, Ma	ryland 2180
			23a. Part1. Enter the disease, of shock, or heart failure. List	r complications that only one cause or	aused the	e death. Do r	not ente	r the mode of dy	ing, such a	as cardiac o	or respiratory arm	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition					CND						Onset and Death
	/Medical Examiner		resulting in death)	Due t	o (or as a c	onsequence	-							
	Examine	_	Sequentially list conditions,	b	- (		-0.							
	led Islt	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Lue t	o (or as a c	consequence	or):						- 3	
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c	o (or as a c	consequence	of):							
8/PU	cate be executed physicien and the burial-transIt	dicai E												
٥	tificating phy as the	ledi												
X Q Q	death certific e ettending p d for use as	clan/Me	JF FEMALE: 23b. Was decedent pregnant in the past 12 months?		birth 2	pregnancy □ Fetal death ne of death		Ectopic pregnand Other (specify)	су				Date of delive Month	ory Day Year
j.	the y th	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Uni										
ທົ	law requires that es been signed b 2 should be deta	by P	Part II. Other significant conditi	ons contributing to	death but r	not resulting in	the un	derlying cause g	iven in Par	t I.	23e. Did tol	bacco use c	ontribute to th	he cause of death?
ğ	equire en si										1 □ Y€	es 2 19 No	o 3∏Prob	pably 4 □Unknown
Records,	The law reste hes be	Completed									24a. Was a autops	y	b. Were auto prior to co death?	psy findings available mpletion of cause of
VIIai		မ င်	25. Was case referred to medical								1□ Yes	2 PNo	1 ☐ Yes	2□ No
	Physician: this certific ral director,	0 8	examiner?	Hospital:	Inpatient	2 ERVOU	tnationt	3 DOA			me 5 Reside	-	Other (Specif	iv)
0	g Phy erthi	Ë	27. Manner of Death	28a. Dat	e of Injury onth, Day Y	28b. T	ime of	28c. Inju	ıry at		28d. Describe ho			y)
0	Attending r death. ector: Afte by the fune	atio	E CONGOIN	gation	inii, Day 1	ear) ir	njury		Yes 2	□No				
UNISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Pla	ce of Injury Iding, etc. (	- At home, fai Specify)	rm, stre	et, factory, office			28f. Location (St City or Town	reet and Nu n, State)	mber or Aura	al Route Number,
_	spital		29a. Certifier 1 ☐ Certifyi	ng Physician: To t	he best of r	ny knowledge	, death	occurred at the t	ime, date	and place,	and due to the ca	ause(s) and	manner as s	tated.
	n 24 l n 24 l he Fu	edicai	one) 2 Medical	Examiner: On the and ma	basis of ex inner stated	camination and d.	d/or invi	estigation, in my	opinion, d	eath occurr	ed at the time, d	ate and plac	ce, and due to	the cause(s)
	To the vithin To the comple	Σ	29b. Signature and title of certifie	or O				29c. Licen	se numbe	r	2	9d. Date sig	gned (Month,	Day, Year)
			Ilu du	1de				1750	245	7		8/22	106	
	AL		30. Name and address of person	who completed ca	use of deat	th (Item 23a) (	Туре, Р	Print)	, _		/	10	2/-	
	14		31. Date filed (Month, Day, Year,	Snyder	100 C	E. Co	2//	011 51	<u>-</u> ک	21156	vey n		1/80	
	Sta Registr		SEP 0	6 2006	Logica	J. H.	do	well			bury m			
							1							

		1 - For State Registr	ar	·	State of	f Maryla	ind / D	epartm Certific	ent of H	lealth Death	and M	lental Hy	giene Reg. No.	200	6	30083
	/siciar	0	s Name (First, Midd	ile, Last)	= (	100	chu	rcl	`			2. Date of De Month	Day	1 26		3. Time of Death
	ledica amine eral	4a. Fecility N	ame (If not institution	yland 6. Sex	Media	nber) Cliv 7. Age (In yr	ter s. last birth	4b.	Lity, Town, or Lity of the Lity  re M		8. Date of Bi	4c.	County of D		ace (State or Foreign	
Direc		Usual Resid	8-3948 ence of Decedent		M 2L2F	67		rs.					8, 19	939		NC
death with the Marylan ms 23a or 28a-f ahow	lied at	10a. State MD	10b. Count	-	undel	10c. 0	City, Town	or Location	Mil	lersv	ille				10	d. Inside City Limits 1 ☐ Yes 2X No
with the	t be notified	10e. Street a	old Orch	ard (	Circle	•		10	. Zip Code	1108			10g. Citi	zen of What	Counti	ry?
, j	Nardrier must	11. Marital S		rried 1	2. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	rces? 2 <b>X</b> No	U.S.					ecfy Yes or N Rican, etc.)	0-	14. Race - A Black, W		tc.
Maryland 21215-0036 nd 2 should be filed within 72 hours af tth and Mental Hygiene. 27 is marked other then "natural", or	r, the Medical E		15. Decede (Specify only higher y/Secondary (0-12) 12	nt's Educ est grade	ation completed) College (1	-4or 5+)	16a.	(Give kind o life. DO N	Usual Occup f work done o T use retired memake	during mo d)	st of worki	ng	16b. Ki	nd of Busine	ess/Indu	ustry
De filed tal Hygie		17. Father's	Name (First, Middle	, Last)								(First, Middle	, Maiden			
Aarylan 2 should be 1 and Mentai 1 a marked o	matic		ne Jones ant's Name/Relation	ship <i>(Typ</i>	e, Print)		19b.	Mailing Ade	ress (Street			White	er, City o	r Town, Stat	e, Zip (	Code)
ore, Maryla is 1 and 2 should of Health and Men item 27 is marks	har trac	Otha	D. Upchu							ard C		e, Mill				21108
	any injury or ot once.	tX☐ Bur 4 ☐ Dor	of Disposition ial 2 □ Cremation nation 5 □ Other (	Specify)		State	cemetery	ont Me	or other place moria	L ¦	Sep. 2		Dav		vil	le, MD
Balt Permit. Departr Importe	eny once	21. Signatu	thomas	EH	Allan			Barr 495	anco a Gov. I	r Son Ritch	s, P.	A. Sev vy, Sev	erna erna	Park Park,	Fun MD	eral Home 21146
Physic /Med		shock,	Enter the disease, or heart failure. Lis Cause (Final condition death)	or complications only one	e cause on ea	aused the de ach line.	ple	M	mode of dyin	ng, such a	s cardiac o	or respiratory a	arrest,			Approximate Interval Between Onset and Death
Exami	ner	Sequentially if any, leading cause. Ente	r list conditions, ng to immediate or Underlying lase or injury	<b>J</b> b.	`	of as a cons										
8760, ate be executed hysicien and	0 16	resulting in	events	c.	Due to (	or as a cons	equence o	f):								
death certific	or use as		ecedent pregnant past 12 months? s 2 MNo	23		irth 2 ☐ Fe ant at time of	etal death		oic pregnancy r (specify)	,			2	23d. Date of Month		y Day Year
ecords, P.O. law requires that the de		Part II. Other	r significant condit	tions cont	tributing to de	ath but not r	esulting in	the underly	ng cause giv	en in Part	: I.			/		cause of death?
# # # #	page 2											24a. Wa auto perf 1 Yes		24b. Were prior death	to com h?	sy findings available pletion of cause of
	director.	examine			ospital:	gratient 2	☐ ER/Out	patient 3[	DOA Oth	05		me 5 ☐ Res		3 MZOther /S	Specify)	boenel
Sing Ph After th	23   17		of Death gral 5 Pend invest	tigation	28a. Date of		28b. T		28c. Injun Wor		:	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	respired
DIVIS tal or Att s after de al Diract	φ i	3 ☐ Suid 4 ☐ Hor		mined		of Injury - At ng, etc. <i>(Spe</i>		m, street, fa	ctory, office				(Street and wn, State		r Rural	Route Number,
DIVISION To the Hospital or Attendithin 24 hours after deatl To the Funeral Director:	completely filled		or 1 Certify only 2 Medica	ing Physi Il Examin	er: On the ba	best of my k asis of exami ner stated.	nowledge, nation and	death occu	rred at the tin ation, in my o	ne, date a pinion, de	and place, a	and due to the ed at the time	cause(s) , date and	and manne place, and	r as sta due to	ited. the cause(s)
To the within	E COM	29b. Signati	ure and title of certifi	<u>h</u>	Tory	m	D		29c. Licens	74	73		29d. Dat	e signed (M	Jenth, D	Pay, Year)
_5		7	Ay W	one	n m-	7-	2	_	OUTH	G	335.	72 St	REE	TIBA	+477	noze, mo 212
Re	State gistra		d (Mohth, Day, Year		- 1	edstrar's Sig	nature	Lan	off)					-		,
DHMH 17 R	ev 1/200	1	VL1	VV			<b>J</b>	1								

State of Maryland / Department of Health and Mental Hygiene 200630084 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 18, 2006 **Physician** 4:15 P.M. Woodrow Harry Unger /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Reeder's Memorial Home Boonsboro Washington | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 28,1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 110 M 2□ F Director 87Yrs. <u>219-14-9310</u> WV Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location wode ! 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28a-f ebor traumatic event, <u>the Medical Examinar man be notified at</u> 1 ☐ Yes 2 No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13826 Exline Road 21750 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 € Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 2 permit. Pages 1 and 2 should b Department of Health and Ments Importent: If Item 27 is marked any injury or other traumatic e Bertha Shade Newton Unger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14017 Orchard Ridge Road Hancock, MD 21750 Duane Unger/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Mt.Olivet Presbyterian 09/21/06 4 □Depation 5 □ Other (Specify) Hancock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street any Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complicate in shat caused the shock, or heart failure. List only one cause on each line. ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Condis Vocanto Anterio Scherchiz 3h /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ğ in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Denvil 24a. Was an Mypoltgraidin autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No neral Diractor: Atter the tilled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 (Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 29a Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZITE MO P1681 Q SEPT 19, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100 340 MILL VASANT DATTA. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

に、 UNGER (1005) Itimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

			For State Registrar	State o	of Maryla	nd / Depa <i>Ce</i>	artment of H	lealth and I Death	Mental Hyg	giene Reg. No. 2006	30085
	Physici		Decedent's Name (First, Middle, II  GARY	ast)	VAUG				2. Date of Dea Month SEPT.		3. Time of Death 3:00 A M
	/Medio		4a. Facility Name (If not institution, g		ımber)		4b. City, Town, or	Location of Deat		4c. County of Deat	
			SUBURBAN HOS					THESDA		MONTGOM	
	Funeral Director		213-42-6437	Sex 1 X M 2 □ F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	9. Bird (, Year) 9. Bird (Co 1, 1944 MARY	hplace (State or Foreign untry) 'LAND
	and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryl 1 sho	ţo	MD. MONTGO	MERY			SILVER SPI	RING			TX Yes 2 □ No
	r 28a	Director	10e. Street and Number	1121(1			10f. Zip Code			10g. Citizen of What Co	untry?
	th wit		11803 IDLE	WOOD RD.			209	906		U.S.A.	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural; or iteme 23s or 28s-1 show imatic event, it a Medical Examinar mark be contilled.	y Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married	Armed Fe 1 ☐ Yes If Yes, G	2 XNo ive		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
ğ	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or 0	Dates:	16a Deco	dent's Usual Occup	ation		16b. Kind of Business/	IITE
21215-003	within 72 ene. then "na	Completed	(Specify only highest of Elementary/Secondary (0-12)			(Give	kind of work done of DO NOT use retired	during most of wo		MORGAN RI	
	be filed value Hygie od other i	Be C	17. Father's Name (First, Middle, La	st)		TIMIT	VIENANCE			Maiden Surname)	WILLI
Maryland	should be and Mental a marked o umatic eve	ToB	REGINAL	'D G	VAUGHN			DA	ISY MAE	FAUFRO	'E
lan	2 8 8 8	İ	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, State, 2	Tip Code)
	1 and Health em 27		JOANNE VAUGHN	/WIFE	206		3 IDLEWO	OD RD.,	SILVER S	PRING, MD.	
5	Pages nent of H		1 ☐ Burial 2 X Cremation 3		State	cemetery, crea	matory or other plac	, , ,			
Baltimore,	permit. Pages Department of I Important: If Its any Injury or o		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lic		1		CREMATO 2. Name and Addres HAMBERS F		2006   OME & CR	RIVERDALE EMATORIUM, F DALE, MD. 2	
	0 0 5 € 0		23a. Part1. Enter the disease, or co	umer							Approximate
	Physician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a PNEUN	each line.		er the mode of dyri	y, such as cardiac	or respiratory ar	rest,	Interval Between Onset and Death  1 MONTH
	Examiner			. Dae to	(or as a conse	quence or,					
	D =	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	D. Due to	(ur as a consu	quaries off):					
	ecuter and -trans	Examln	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(or as a conse	augus of):					
8760,	icate be executed physician and the burial-transit	dical E		d	(or as a conse	quanta or).					
9		•	IF FEMALE:			1010					
O. Box	at the death certifii by the attending I tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregr birth 2 Tee nant at time of nown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
1	£ 26 €	by Ph	Part II. Other significant conditions	contributing to d	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
g	quires an signi uld be		HEMOPTYSIS, C	OPD, ULO	CERATIV	E COLIT	TIS		1 □ Y	es 2⊡No 3¶Pr	obably 4 Unknown
Hecords,	e law has b	Completed							24a. Was autop perior	sy prior to o med? death?	topsy findings available completion of cause of
Vita	ifcian: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only o	Λ	2□ No
5	S	To	examiner? 1 ☐ Yes 2 ☒ No			☐ ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing H	lome 5 ☐ Resid	ence 6 □Other (Spe	cify)
č	ing After une		27. Manner of Death 1 XNatural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time o Injury	f 28c. Injun Worl	y at k?		ow injury occurred	
Division	deat deat ctor: / the	flcat	2 Accident investigat 3 Suicide 6 Could not	be one Blee	e of Injury - At	home farm str	M 1 1	Yes 2 □No	28f. Location (S	treet and Number or Ru	ral Route Number
2	2550	Certification:	4 Homicide determine	build	ling, etc. <i>(Spec</i>	ify)	and the state of t		City or Tow	n, State)	and the state of t
•	To the Hospital of within 24 hours at To the Funeral Completely filled it	edical (	29a. Certifier 1\overline{\text{Certifying}} Certifying 2\overline{\text{Medical Ex}} Medical Ex	aminer: On the b	e best of my kr pasis of exa <i>m</i> in nner stated.	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	and due to the curred at the time, o	eause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2. To the I complet	W	29b. Signature and title of certifier				29c. License	e number		29d. Date signed (Mont	n, Day, Year)
			the first	- MD			DO	060117		SEPT. 3, 2	006
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ERIC J. PARK, M.D. 9901 MEDICAL CENTER DR., ROCKV								950
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature		MIEK DK.	, KUCKVI	ыь <b>с, МИ.</b> 20	טכס
	Registr	ar	SEP - 7	2006	magnetic of	de do	we				

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Christopher John Vogel

Physicia		1- For State Registrar 1. Decedent's Name (First, Middle,Last)	ate of Death	2. Date of Death	1. No. 200	5 300
Priysicia lical Exami	31107	Christopher John Vogel		Month September	Day Year 8, 2006	1330 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Deat	.l h
		5892 Bonnie View Road	Elkridge		Howard	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	·			rthplace (State or
Director		213-88-1642 1X M 2 F 46  Usual Residence of Decedent	Yrs Months Days Hours	Min 07/07/	1960 Foreign	puntry) PA
any	ŀ	10a. State 10b. County 10c. City, Town	or Location			10d, Inside City Limits
* *	۱ ـ	MD Prince Georges Bowie				1 XYes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene item 27 is marked other than "natural", or items 23a or 28a-f show irranmatic event, the Medical Examiner must be notified at once.		12421 Stafford Lane	20715	ī	USA	
ms 2.3	era	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican		14 Race - Amer White, etc.	ican Indian, Black,
r deat	Funeral	1 Yes 2 X No		, , , , , , , , , , , , , , , , , , , ,		
s after	ð	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 No specify  Decedent's Usual Occupation (Give	land of work done	Specify Whi	
hour "natu	Completed		during most of working life, DO NOT		160. Kind of Business/	maustry
led within 72 Hygiene other than '	lg e		ales		Construct	ion
ocemit Pages I and 2 should be filed within 7 Department of Health and Neutral Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	녌	17 Father's Name (First, Middle, Last)		's Name (First, Middle, Ma	aiden Surname)	
be fill ntal F rked ent, t	Be	Arthur J. Vogel  19a Informant's Name/Relationship (Type, Print )  19		Secker		
I and 2 should be f Health and Mental item 27 is marked r traumatic event,	2		b Mailing Address (Street and Num			e, Zip Code)
I and 2 shou Health and I item 27 is r		0)1101111111111111111111111111111111111	2421 Stafford La			
4- = 9			of Disposition (Name of cemetery, cory or other place)		20c. Location - City or	
permit Page Department o Important: injury or oth			Crematory	09/15/2006		
ermit eparti upor		21. Signature of Funeral Service Licensee	22. Name and Address of Facility			
	1,3	23a art I. Enter the 180 me, complications that caused the death. Do no	16000 Annapoli			Approximate Interv
hysician /Medical	- 1	failure List only one cause on each line.		ardiac or respiratory arres	st, snock, or near	Between Onset an
xaminer	- 3	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxicati	Lon			Deati
) P		b				1
	Je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated  c.  Due to (or as a consequence of)				
ecuted and transit		events resulting in death) Last Due to (or as a consequence of) d.				
a a e	Medical	Y UNPENDED AMENDED	20. f ME 000 10	16 106 1177		
icate be ex physician the burial	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	.28a-f.perME.g860.10	/6/U6 TT	23d Date of deliver	у
ertific ding p		past 12 months.		pregnancy	Month	Day Year
Tall or Attending Physician: The law requires that the death certificate death  al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as t	sician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
the d by the	Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Pa	art I 23e Did tob	acco use contribute to	the cause of death?
s that gned	þ			1 Yes	2 <b>V</b> No 3 Pro	bably 4 Unknown
v require s been si should b	Completed			24a Was ar	24b. Were au	utopsy findings availab
law r has b e 2 sh	힐			autops perform	ned? death?	completion of cause of
The ficate	3		Of Diago of Dooth	1 Yes 2	No 1 ✓ Y	es 2 No
vsician: The his certificate director, page	a	25 Was case referred to medical examiner?  Hospital. 1 Inpatient 2 ER/O	26 Place of Death outpatient 3 DOA Other	7	esidence 6 🗸 Othe	r Sanna
ling Phy After thi funeral d	2	27. Manner of Death 28a Date of Injury 28b	Time of Injury 28c Injury at Work		ow injury occurred	Ocene
tending eath or: Af the fun	io	1 Natural 5 Pending F-1 0/9/2006 F-	1 Yes 2 v	No ,		
or Attence after death Director:	icat	28e Place of Injury - At home, for	nd 1:25 pm X arm, street, factory, office building, et	tc 28f. Location (St	reet and Number or Ru	
ital or its afte ral Din	Certification:	Suicide 6 XCould not be determined (Specify) School bus	3	or Town, Sta	mb 5892 Bonn	ie View Road
Hospital 24 hours Funeral tely fillec	2	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, de				
To the Hospital or Attending Physician: The law requires that the death certification and the state of the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it.	ledical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated				
<u>-</u> 78	Re	29b. Signature and title of certifier	29c. License number	. [	29d Date signed (Mo	onth, Day, Year)
		Warmer Melhale	O.C.M.E.		September 9, 20	006
		30 Name and address of person who completed cause of death (Item 23a)				
)		30 Name and address of person who completed cause of death (item 25a)				
1		Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore	e, MD 21201		
Si Regis	tate		111 Penn Street, Baltimore	e, MD 21201		

State of Maryland / Department of Health and Mental Hygiene Registrar Remove #23a- line c per/phys Certificate of Death 2006 3. Time 00 am 8 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 30, 2006 11:05 Pm WINDEL ELIZABETH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 577-20-7038 97 Director May 19, 1909 Germany Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location Show 10d. Inside City Limits ir then "natural", or itams 23a or 28a-f sho the Medical Examiner , ust be notified at Maryland 1 ☐ Yes 2 📉 No Frederick Mount Airy Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5824 Catoctin Vista Drive 21771 United States death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐ Yes 2 X No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🎇 No δ Specity: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Importent: if item 27 is marked other th any niury or other traumatic event, the once. 12th Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johann Suess Franziska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ulmer / Daughter Jane 5824 Catoctin Vista Dr./ Mount Airy, MD 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory Sept. 2,2006 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Taymond or complic 1621 Opossumtown Pike/ Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or Immediate Cause (Final disease or condition **Physician** SEPSIS tours /Medical resulting in death) Due to (or as a consequence of): Examiner BONEL ACUT2 DASTRUCTION SMALL HOUSE Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and the burial-transit TINKHOWN Due to (or as a consequence of): Box 68760. Physician/Medical d use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, cete has been sig. page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? hasr 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 ☐ No 1☐ Yes Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 7€ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funaral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the I 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 264 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Seventh St./ Frederick, Maryland 21701 Ronald Ε. Miller /

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 6 2006

32. registrar's Signature

			For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of Hertificate of L		lental Hyg	giene eg. No 2006	30088
	Pnysici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dear Month	Day Year	3. Time of Death
	/Medic	al		uth	Wilmoth	4h Cihi Toura ar	Location of Death	Septemb	er 3, 2006	
	Examin	er	4a. Facility Name (If not institution, given ATRIA ASSISTED			4b. City, Town, or SALISB			WICOMIC	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		rthplace (State or Foreign ountry)
	Director		232–14–5620	□ M 2ÅF	90 Yrs.	Months Days	Hours Min.	1/23/1	916 Wes	st Virginia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	ō	Maryland Wicomi	co	Salisb					1 XYes 2 No
	r 28a	irec	10e Street and Number	Aggigted Id		10f. Zip Code		1	log. Citizen of What C	ountry?
	th witi	al D	1110 Healthway	Drive	LVIIIg	21804			USA	
Maryland 21215-0036	72 hours after death with the Maryland naturel', or Itams 23a or 28a-f show alsal Examiner must be matified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Married 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2K No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
5-0	72 hours "naturel", olical Ex.	etec	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occupa kind of work done d	luring most of work	ing	16b. Kind of Business	s/Industry
121	d within 72 jiene. r then "ni	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired)	)		Tonasantan	t. 0
d 2	Hyg Hyg		17. Father's Name (First, Middle, Last)		BOOK	keeper	18. Mother's Name	e (First, Middle,	Investmen Maiden Sumame)	r Company
an	o d ta	To Be	Allen Schultz				Myria C	lin Rob	erts	
ary	d 2 should th and Mer ?7 Is marke traumatic		19a. Informant's Name/Relationship (		19b. Maili	ng Address (Street a	and Number or Run	al Route Number	r, City or Town, State,	Zip Code)
	C = 64 F	1	Jean S. Pierce,	/daughter	001 DI ( D'	-141	1	the same of the sa	MD 21830	-T Cont
lore	ges 1 au it of Hea if item or othe		20a. Method of Disposition 1 Ma Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo	natory or other place TAM Memoria	1 9/7/		St. Alban	
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny in ury or ot		* 4 □ Donation 5 □ Other (Specify 1. Sign, IIII of Fineral Service Licer							
Ba	permi Depa Impo eny ii		Hourd 7. 0	mpro	-10			·		Association 804
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not en	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		nomon	of the	Ovary			8 mos.
ı	Examiner			Due to (or as a	consequence of):		/			
ŀ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as a	consequence of):					
	be executed sician and burial-transit	Examiner	that initiated events	С.						
90,	e exe		resulting in death) Last	Due to (or as a	consequence of):					
8760,	icate b physic the b	dlca		_ d						
O. Box 6	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 19 Unknown	2 ☐ Fetal death 3 [	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
σ.	res that i igned by be deta	by Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute (	to the cause of death?
rds	v requires been sign should be							1 🗆 Y	es 2⊠No 3∏P	robably 4 Unknown
Vital Records,	8 S CA	Completed						24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
<u>=</u>		Con						perform 1 Tes	med? death?	
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deat	ASS	isted Livi	
of	Phys r this ral dir	- To	1 ☐ Yes 2 🏲 No  27. Manner of Death	28a. Date of Injury	28b. Time o	IL 3L DOA	4   Nursing Ho		ence 6 □Other (Spe ow injury occurred	ecity)
	Attending Ph r death. ector: After thi by the funeral	ation	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	Year) Injury	f 28c. Injury Work M 1 \(\(\)\	(? Yes 2□No			
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, st	reet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
٥	itel or irs afte rel Dir led in l									
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical		nysician: To the best of miner: On the basis of and manner state	examination and/or in					
	To the within	Me	29b. Signature and title a certifier	) un		29c. License	24986	2	29d. Date signed (Mon	th, Day, Year)
	10/2		30. Name and address of poson who	- 1	eath (Item 23a) (Type,	Print)	Salis bun	n md	21001	
	Sta	ite	31. Date filed (Month, Day, Year)	7 - ( -		13(01)	- VI (1 ) 8 - V	) / (		
	Registi		SEP 0 6 2	006 Marie	r's Signature	ante				

State of Maryland / Department of Health and Mental Hygiene, For State Registrar 30089 Certificate of Death Rea. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician **′**3, September 2006 White 7:55 Michael Tracey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 39 vrs If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days 10XM 2□ F 218-88-7839 Director 8/15/1967 Maryland Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10c. City. Town or Location 10a. State 10b, County 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Maryland Wicomico Salisbury Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 847 Shad Point Road 21801 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hyglene. and the fire and the file marked other than "natural", or its ury or other treamatic event, the Medical Examinary or other treamatic event, the Medical Examinary. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Musician/entertainer Entertainment 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) Eugene White Arleen McGowan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 847 Shad Point Rd., Salisbury, MD 21801 Michelle White/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 9/7/06 \* 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery Salisbury, MD 21. Signature of Funeral Service Ligensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 bruse 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner use as the burial-transit and Due to (or as a consequence of) Box 68760 the attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9□ Unknown 9 I Unknown signad by Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 10 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2/2 No Vital Be or Attanding Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 No 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tyes 3□ DOA o After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Teath 28h Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation М 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 T Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation in my calabia. Medical 29a, Certifier Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type ngistrar's Signature filed (Month, Day, 31. Date Year State 0 6 2006 Registrar

to

88-7839

Michea

			For State	State of N	Marylar	•			ealth a			giene	200	6	3009	
			Registrar  1. Decedent's Name (First, Middle, La	st)			inica	10 01 1	Joann		2. Date of Dea				3. Time of Death	-
п	Physici		Erma Dale	Willi	ams						August	Day 31	Yea 200		8:45P M	
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City	, Town, or	Location o	of Death			County of De		<u> </u>	_
	LAUITIII	C1	12101B Glissans	Mill Roa	d			Unio	on Br	idge			Fred	leri	ck	
	Funeral		Social Security Number     6. S		Age (In yrs.	last birthday)	If Unde	er 1 Year			8. Date of Birth (Month, Day	Yearl	9. B		ce (State or Foreign	,
	Director		232-92-6991	I □ M 2 1 1 F	97	Yrs.	WOITE	Days	Tiours	William.	0ct. 6	, 19	908 We	st	Virginia	
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. Ci	ty. Town or Lo	ncation							10	t. Inside City Limits	_
	f cho	ō	Maryland Freder	·ick			Hn	ion F	3ridge	<b>e</b>					1 ☐ Yes 2 🔀 No	
	the t	Director	10e. Street and Number	TCK				ip Code	71 149			10g. Cit	izen of What (	Countr	y?	
	3a or		12101B Glissans	Mill Rd	_				2179	1			U.S	.A.		
	deatl	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Dec	edent of Hi			cify Yes or No- Rican, etc.)		14. Race - An			_
9	atter or ite	/Fu	1 Never Married 2 Married	1 Yes 2			ıı rəs, sp 1 □ Yes	4.5	Specify:		nican, etc.)		Black, Wh Specify:			
8	within 72 hours atter death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow than Madigal Examinan must be notified at	d by	3 Widowed 4 Divorced	Year or Date	s:									Whi		_
15	"nat	Completed	15. Decedent's E (Specify only highest gra			16a. Dece (Give	kind of w		lurina most	t of workii	ng	16b. Ki	ind of Busines	s/Indu	stry	
7	withii ene. than	dmo	Elementary/Secondary (0-12)	College (1-4d	or 5+)		areg		,			pri	vate h	Ome	· S	
0	Hyg other	Be C	17. Father's Name (First, Middle, Last,	)					18. Mothe	er's Name	(First, Middle,			J		_
lan	fenta fenta frked rked	To B	Alfred Grat Will	iams						Edna	a Brown					
Baltimore, Maryland 21215-0036	and h		19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Addre	s (Street a	and Numbe	er or Rura	l Route Numbe	r, City o	or Town, State	Zip (	Code)	
Σ.	and and and and and and and and and and		Glenna E. Hazelwo	od/ niece		12101			ns Mi				ridge,			
Ore	t of H If ite		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3			Place of Dispo cemetery, crei	natory or	ame of other place	<b>a</b> )		ate		ocation - City o			
Ξ	t. Partmen		4 Donation 5 Other (Special		Men	norial				•	/8/06		nceton		'V	_
Bal	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f ehow appringury or other traumatic event, the Madical Examinat must be notified at ODGs.		21. Signature of Funeral Service Lice	Seas	ler			<sub>ina Adares</sub> hurch			zler Fu w Winds					
			23a. Part1. Enter the disease, or com	plications that caus	ed the deat								MU ZI	1	pproximate	_
	Physician		shock, or heart failure. List only Immediate Cause (Final												nterval Between Onset and Death	
)	/Medical		disease or condition resulting in death)	a. <u>aSPil</u> Due to (or	as a consec	nuence of):	neur	non	$\omega$					-		_
	Examiner		On a section to the second section	seni	1	emes	Hia	)							3145	
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consec	juence of):								t	0	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. adva	un ce	da	e		· · · · · · · · · · · · · · · · · · ·					_		
8760,	icate be executed physician and s the burial-transit	al E		Due to (or	as a conseq	(uarica oi):	)									
687	The law requires that the death certiticate be executed ste hes been signed by the attending physician and bage 2 should be detached tor use as the burial-transit	adlcal	`	_ d												_
Box (	eath certitic attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor									23d. Date of d	eliven	1	
ă	death e atte d tor	icla	in the past 12 months?	1□Live birth 4□Pregnant	at time of c		JEctopic   Other (s	oregnancy specify)					Month	Ċ	ay Year	
P.0.	that the de ed by the detached	hys	9 □ Unknown	9□ Unknowr	1											_
Ś	res tha igned be de	by Physiclan/Med	Part II. Other significant conditions of	contributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.				4		cause of death?	
ord	w requir been si should										1 U Y	es 2	<b>⊠</b> No 3□I	Probai	oly 4 Unknown	_
ec	law i	Completed									24a. Was a autop:	sy	24b. Were prior to	autops com	y findings available pletion of cause of	ı
E	: The	S									perfor 1 Yes	meg:/ 2 M No	death?	s 2	Ø No	
ži Ži	Physician: this certitice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	7/1			OA Othe	3r		(Check only or					_
ot	Phys r this ral di	5	1 ☐ Yes 2 🐧 No 27. Manner of Death	28a. Date of li	njury	ER/Outpatier 28b. Time o		UA	4 🗆 140		ne 5 Resid			ecify)		-
on	th. : Atte	tlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month,	Day Year)	Injury	м	28c. Injury Work 1 □ \	(? Yes 2 ☐ !			•	,			
Division of Vital Record	Attended of dead of de	ifica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of	Injury - At h	ome, farm, str	eet, facto	ry, office		2	28f. Location (S City or Tow	treet an	d Number or i	Rural i	Route Number,	
Ö	tal or	Certification:	4 Ditolification	building,	etc. (Specil	·y)	_				City of Yow	n, State	"/			
	To the Hospital or Attending Physician: The lawthin 24 hours after death. To the Funeral Director Atter this certificate hes completely litled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the be miner: On the basis	st of my kno	owledge, deat	h occurre vestigatio	d at the tim	ne, date and pinion, deal	d place, a	and due to the c	ause(s)	and manner	as sta	ed. ne cause(s)	
	the hin 2, the I mplet	Med	one)	and manner	stated.			c. License								_
	5 ± 5 g	-	29b. Signature and titlerof centifier	26					1338	34	-		te signed (Moi			
	WH		20 Name and address	completed at	of donth /lic	n 23a\ /T		7007	228	/		07	-07		000	_
	5		30. Name and address of person who Susan Brinkley	Cause o		homas		son D	r., #	200	Frede	ric	k, MD 2	2170	02	
	Sta	te	31. Date filed (Month, Day, Year)		strar's Signa		baste									_
	Registr	ar	SEP 0.5.2	HIIIh   July	eve	Dr a	DAMEL	/								

			For State Registrar	State of M	Marylar	nd / Depa <i>Ce</i>	artmen <i>rtificat</i>	t of H e of L	ealth a Death	and M		giene 2	006	3009	2
	Physici	an	1. Decedent's Name (First, Middle		Wes	.+					2. Date of Dea Month	ath Day	Year	3. Time of Death	м
	/Medic Examin		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death	Aug.		2006 nty of Death	1:56p	
	LXamiii	CI	Anne Arundel					Anr	apol:	is		A	nne Aı	rundel	
	Funeral		5. Social Security Number	6. Sex 7 152 M 2 ☐ F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Year)	9. Birth	place (State or Foreigntry)	gn
	Director		418–18–8951 Usual Residence of Decedent	<b>M</b> 101	82	Yrs.					Apr. 6	1924		AL	
	Maryland	tor	10a. State 10b. County	Arundel	10c. Ci	ty, Town or Lo		erna	Park					10d. Inside City Limit 1 ☐ Yes 2 🖾 N	
	or 28	lrec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
	23a c	ral	405 Ben Oaks D	rive, W.				21	146				USA		
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "neture!", or iteme 23a or 28e-f ehow or other treumatic event, the Maratal Examinar must be mailied at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 17 Yes 2 [ If Yes, Give Year or Date:	s? ∃No V	AMTT	Was Deced If Yes, special 1 Tes		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14. F Spe	lace - Ameri llack, White		
5-	72 h	ete	15. Decedent (Specify only highes			(Give	dent's Usua kind of wo	rk done a	uring mos	t of worki	ng	16b. Kind of	Business/Ir	ndustry	
12	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4d	or 5+)	_	<i>во кот и</i> Jawyei		,			Priv	ate Pi	ractice	
<b>D</b>	Hygi other ent,	Be Cc	17. Father's Name (First, Middle, L						18. Mothe	er's Name	(First, Middle,	Maiden Surr	iame)		
lan lan	Aental Aental rked o	ToB	Thomas Jeffers	on West					Mal	bel d	Jones				
Mary	id 2 should th and Men 27 is marke treumatic		19a. Informant's Name/Relationsh Lelia H. West/				-				., Seve	-			
Baltimore, Maryland	Pages 1 and 2 nent of Health a ent: If Item 27 is ury or other tree		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from Sta		Place of Dispo cemetery, cre etro Cr	osition (Nai matory or o	ne of other place	T		2006	20c. Location	n - City or T	own, State	
Balti	permit. Page Department Importent: If eny injury or once.		21. Signature of Funeral Service L		-					š, P	-			neral Hom D 21146	e
8760,	death certificate be executed  By Remain and a stending physicien and a for use as the burial-transit  Carrier and for use as the burial-transit  Carrier and a stending physicien and a stending physicien and a stending physician are a stending physician and a stending physician are a stending physician and a stending physician are a stending ph	Ical Examiner	shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to for a Due to for a Due to for a										Interval Between Onset and Death,	
P.O. Box 68	y th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 🗍 Feta at time of c	aldéath 3[	□Ectopic pi □ Other (sp						Date of deliv Month	ery Day Year	
	gned be de	ρ	Part II. Other significant conditio	- 1	but not res	-	inderlying o	ause give	n in Part I.		_	obacco use c		the cause of death? bably 4 <b>Z</b> Ünknow	/n
000	aw requir is been si 2 should i	Completed	Spinol co	ord stro	ke						24a. Was		b. Were aut	opsy findings availab	le
Ě	The age	E O	paritonitis							-	perfo		death?	ompletion of cause of	
/ita		Be (	25. Was case referred to medical examiner?							of Death	Check only o				_
5	tending Physicien: Jeath. tor: After this certific the funeral director,	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 ZNopa		ER/Outpatie			4 1110	-	me 5 Resid			fy)	
n C	ling After une	lo lo	27. Manner of Death  1 Avatural 5 Pending		Day Year)	28b. Time o Injury	M	28c. Injury Work	at ? ′es 2 🗆		28d. Describe h	low injury occ	curred		
Division of Vital Records,	of or Attending after death. I Director: After din by the fune	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	Injury - At h etc. (Speci						28f. Location (S City or Tox		mber or Rur	al Route Number,	
	Hospite 4 hours Funerel ely fille	edical C	29a. Certifier 12 artifyin (Check only one) 2 Medical B	Physician: To the bu examiner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred ovestigation	at the tim	e, data an inion, dea	d place. th occurr	and due to the o	date and place	manner as e, and due t	taled o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1_			29	c. License	number			29d. Date sig			
			> kul / bet	un				02	1804			8-3	1-200	56	
	44-1		30. Name and address of person of Persons			п 23a) (Туре, 4 А М	Print)	1-1-1	opdo	, /	ad a	1461			
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 5 2	32. Regi	strar's Sign		<i>M</i> =		0						

hysici /Medic	4	1. Decedent's Name (First, Middle, Last  AUTCE M.		ice L.	Walls		2. Date of De Month	Day Yes	3. Time of De
Examin		4a. Facility Name (If not institution, give	.1 /		4b. City, Town	n, or Location of De	,	4c. County of D	
		YENINSULA REGIONOL	Medica	Cente	1611=4==1.74	SAUSE			CAMICO
ineral rector		5. Social Security Number 6. Se 231-50-1172	37	(In yrs. last birtho	Months Day		1 8. Date of Bi (Month, Da 05-17-	1936 D	Birthplace (State or F Country) elaware
ehow Late	'n	10a. State 10b. County	1	10c. City, Town o					10d. Inside City I
28a-f	ect	Delaware Sussex  10e. Street and Number		Seafor	10f. Zip Cod	•		10g. Citizen of Whal	
3a or	ă	806 Magnolia Dr			1997.			US	Country :
Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other treumatic avant. Its Medical Examination at colling at once.	Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give		13. Was Decedent of If Yes, specify C		(Specify Yes or No erto Rican, etc.)	5-1	
LEXE	d b	3 Widowed 4 Divorced	Year or Dates:					Specify:	
than nati	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(C	ecedent's Usual Oc Give kind of work do fe. DO NOT use rei emaker	ne during most of t	working	16b. Kind of Busine Home Owne	
other.		17. Father's Name (First, Middle, Last)			41102101	18. Mother's N	Name (First, Middle	, Maiden Sumame)	
arked o	To Be	Lester John Denn	is				Vilkerson	, ,	
27 ia m treum		19a. Informant's Name/Relationship (7) William W. Walls -			Magnolia			per, City or Town, State	e, Zip Code)
other		20a. Method of Disposition		20b. Place of D	isposition (Name of		Date	20c. Location - City	or Town, State
nt: If		1 ØBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation, 5 ☐ Other (Specify)			crematory or other p Cemetery		05/2006	Blades, I	DE
Importa any Inju once:		21. Signature of Fune Mervice Licens  Julian A. Crans	Valuat		22. Name and Ad Cransto P O Box	dress of Facility On Funera x 967, Se	l Home	E 19973	
		23a. Part1 Enter the disease, or compositions, or heart failure. List only o	lications that caused the	e death. Do not					Approximate Interval Betwe
sician		Immediate Cause (Final disease or condition	a. MULTINE :		ZGAN FAN	war			Onset and De
edical miner		resulting in death)	Due to (or as a	consequence of)					(Or7
minei	_	Sequentially list conditions, if any, leading to immediate	SESSIS						304K
nsit	nine	cause. Enter Underlying	ENGYEW	orisequence of)					I SEK
an and rial-tra	Examiner	that initiated events resulting in death) Last		consequence of)					10000
physician and s the burial-transit	dical		d						
ettending p	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of o	delivory
ed by the etter detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 □Ectopic pregna 5 □ Other (specify)			Month	Day Yea
igned by be detac		Part II. Other significant conditions co	ntributing to death but	not resulting in th	e underlying cause	given in Part I.	23e. Did 1	tobacco use contribute	to the cause of dea
sigr d be	ed by						_ 10	Yes 2□No 3□	Probably 4 Onl
2 2	Completed								
certificete rector, peg	BeC	25. Was case referred to medical examiner?				26. Place of D	1 Yes		65 20 140
this certificete har al director, pege	10	1 Yes 2 No	Hospital:	2 ER/Outpa	itient 3 DOA	Other: 4 Nursing	gHome 5□Resi	idence 6 Other (S)	pecify)
After	Certification;	27. Manner of Death  1 Natural 2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Tim Inju		njury at Vork? □ Yes 2 □ No	28d. Describe	how injury occurred	
	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm (Specify)	, street, factory, offic	Ce	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number
I Direct		29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of a	xamination and/o	eath occurred at the r investigation, in m	time, date and pla y opinion, death of	ace, and due to the courred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
a Funeral Direct etely filled in by	Ö		//		29c. Lice	ense number		29d. Date signed (Mo	onth, Day, Year)
To the Funeral Direct completely filled in by	Medical	29b. Signature and title of certifler							
To the Funeral Director: After completely filled in by the funer.	Medic	29b. Signature and title of certifler	ompleted cause of dea		D	535	51	Ave 30	2006

			For State Registrar	State of Maryland	d / Department of H Certificate of	lealth and M <i>Death</i>	ental Hygier		30094
	Physici	an	Decedent's Name (First, Middle, Last)	1.1011	- 0		2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give:	street and number)	4b. City, Town, o	r Location of Death	trigust =	4c. County of Death	122:25
	LXaiiiii	Ç1	0	ONALMEDICAL	CENTER S	ALISBUR	4	1	nico
	Funeral Director		5. Social Security Number 6. Sec	7. Age (In yrs. It	ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Yes 5-7-3	ar) 9. Birthp Cour	place (State or Foreign mtry)
	yland		10a. State 10b. County	10c. City	, Town or Location			1	Od. Inside City Limits
	e Mar	ctor	MD WICON	11co 5	ALISBURY				1 Yes 2 □ No
	with th	Dire	10e. Street and Number	A	10f. Zip Obde		10g.	Citizen of What Cour	
	ns 23	Funeral Director	10015 DELAND	12. Was Decedent Ever in U.S	S. 13. Was Decedent of H	O 2 Hispanic Origin? (Spe	cify Yes or No-	14. Race - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appropriate: If item 27 is marked other than "natural", or items 23a or 28a-f show appropriate from force.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		an, Mexican, Puerto l	Rican, etc.)	Black, White,	
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	nation during most of working	16b.	. Kind of Business/In	dustry
121	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	IIIO DO NOT use retired			USDA	
ק	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)	\	203/00/0		(First, Middle, Maid	en Sumame)	
Maryland	Menta Menta arked	ToE	WILLIAM HAND	Y WALLE	R	LILLIA	N STA	INFORD	
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Street	Λ	_		Code)
	Healt tem 2 other		20a. Method of Disposition	20b. PI	ace of Disposition (Name of	D	SALISBUR ate 20c.	Lecation - City or To	1802 own, State
ê E	Pages nent of nt: If I		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	RING HILL CEM	0/-1	nh t	JEROSE!	Mn
Baltimore,	permit. Departm Importa any Inju		21. Signature of Fuheral Service License		22. Name and Addre		INNIE S	MITH FI	H
	₫Ω <u>=</u> € a		23a. Part1. Enter the disease, or compli	a Krind	917-W.15			BURY, MD.	21801
	Dharisian		shock, or heart failure. List only or Immediate Cause (Final	ie cause on each line.	Do not enter the mode or dyin	ig, such as cardiac o	r respiratory arrest,	,	Approximate Interval Between Onset and Death
Ł	Physician /Medical		disease or condition resulting in death)	Due to (or as a copsequ	uence of): /				
	Examiner		Sequentially list conditions,		$\mathcal{N}($				
Т	led sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):				
,	execut n and ial-trar	Exan	that initiated events resulting in death) Last	Due to (or as a consequ	rence of):				
68760,	icate be executed physicien and s the burial-transit	dical		J					
_		•	IF FEMALE:	0. 16					
S. Box	Attending Physician: The law requires that the death certific act death.  act death.  act After this certificate has been signed by the attending p.  by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown (	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy	,		23d. Date of delive Month	Pay Year
P.0.	thet the	F.	Part II. Other significant conditions cor	tribéting 4q death but not resu	etting in the underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
rds	quires the in signed uld be dei	ed by	-ESRD-1	11)			1 ☐ Yes	2 <b>94</b> % 3 □ Prob	eably 4 Unknown
9 0 0	ne law requir hes been si ge 2 should i	Completed	- Ca - Bru	ish e NI	ehs.		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Ē	hysician: The la nis certificete he: I director, page 2	Sol					performed	death?	
ĬŞ.	sician certifi rector	Be	25. Was case referred to medical examiner?	lospital:	ER/Outpatient 3 DOA Oth	26. Place of Death			
o	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Injur	y at 2	ne 5 Residence 8d. Describe how in	6 ☐Other (Specifically)	"
ion	ending sath. or: Aft he fun	atlo	Natural 5 Pending investigation	(Month, Day Year)	Injury Wor M 1 □	K? Yes 2 □No			
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funers! Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, street, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura ate)	I Route Number,
	To the Hospital or within 24 hours afte To the Funersi Dir. completely filled in		29a. Certifier Certifying Phys	sician: To the best of my know	wledge, death occurred at the tin	ne, date and place, a	nd due to the cause	(s) and manner as si	hetel
	n 24 h he Fui pletely	Medical	(Check only 2 Medical Examinations)	on the basis of examinati and manner stated.	ion and/or investigation, in my o	pinion, death occurre	d at the time, date a	ind place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1	29c. Licens	e number	29d. [	Date signed (Month.	Day, Year)
,				111/	Nednory D	-256	>//	8/31/0	6
			30. Mame and agoress of person who do	inholded tauste of death (Item 1000 / 740	23a) (Pype, Print)	Dirisa	m 57 (	alinGans	Mndieni
	Sta		31. Date filed (Month, Day, Year) SEP 0 5 21	32. Registrar's Signat	ure			-un -vvy	(1) 1-1007
	Registr	ar	SEP 0 5 21	106 Magree	J. Snast,				

		1 - For Stete Registrar	State of Marylar			of Health a of Death		_	ene g. No 2	006	30095
Physic		Decedent's Name (First, Middle, Last)     EVELYN ANN	YINGER					Date of Death Month eptembe	Day	Year 2006	3. Time of Death 6:25 A M
/Med Exam		4a. Facility Name (If not institution, give si Washington Adven	The state of the s	1		own, or Location of koma Par				ontgome	ery
Funera Directo		5. Social Security Number 6. Sex 218−24−6724 1□	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	Min.	Date of Birth (Month, Day, Teb. 16			place (State or Foreign oftry) cginia
fanyland I show	or	Usual Residence of Decedent  10a. State 10b. County  Md. Montgom		ty, Town or Lo						1	0d. Inside City Limits
or 28a-	Director	10e. Street and Number			10f. Zip (	Code				of What Cou	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, I'm Madical Exp., Let marke to Letter and Department of the Madical Exp., Let market be a solited at the madical Exp., Let may be a solited at the solite	by Funerai	19801 Georgia Av  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	enue  2. Was Decedent Ever in UAmmed Forces?  1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decede	0833  Int of Hispanic Oring Cuban, Mexican  No Specify:	n, Puerto Ric	v Yes or No-	14.	ed Stat Race - Americ Black, White, Decify:	can Indian,
within 72 hourses one. "natural then "natural then "natural then "natural then "natural then "ne Madical E."	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual kind of work DO NOT use nemake	,	t of working	1		of Business/In	dustry
uld be filed Mental Hygie irked other	To Be Co	12 17. Father's Name (First, Middle, Last) Jerry Saylor	0	TIO	пешахе	18. Mothe	er's Name <i>(F</i> .a <b>r</b> a	irst, Middle, M Saylor	aiden Su		
d 2 sho th and h		19a. Informant's Name/Relationship (Type David C. Yinger				Street and Numbergia Ave.			-		333
ages 1 ar		20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b.	Place of Dispo cemetery, crei	matory or oth	her place)	Date 9/8/0			tion - City or To	
permit. Pages Department of Important: If I eny injury or		21. Signature of Funeral Service License	e 0 1		Name and	Address of Facility I H. Bar Box 50	ber Fu	neral	Home		
Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	liogen	er the mode						Approximate Interval Between Onset and Death
/Medica Examine			Due to (or as a consecuence of the consecuence of t	40 car	deal	infair	teen				Hours
eath certificate be executed attending physicien and for use as the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	orone	my o	ntay,	dise	use			Years
the death certificate by the attending phys	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown	Sc. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pre				230	d. Date of deliv	ery Day Year
w requires that the de been signed by the should be detached	5	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying ca	use given in Part I	l.		acco use s 2 🗆 I		he cause of death?
The larate has	Completed							24a. Was an autopsy perform 1 Yes 2	,	24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of
sicia serti	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	] ER/Outpatie	nt 3□ DO	Other	- 1	Check only one 5 ☐ Resider		Other (Speci	(v)
a figure	Certification: T	27. Manner of Death 1 12 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	Bc. Injury at Work? 1 □ Yes 2 □	No	d. Describe how			
		4 Homicide determined	28e. Place of Injury - Ath building, etc. (Spec	ify) 				City or Town,	State)		al Route Number,
To the Hospital or within 24 hours after To the Funeral Direction	Medicai		ician: To the best of my kn er: On the basis of examin and manner stated.								
To th withir To th comp	Me	29b. Signature and title of certifier  Mulhall	18 Chen	113	29c.	G42	79	29		signed (Month,	
6		30. Name and address of person who co	, M.D. 152	25 SHA	Print) DY GRO	OVE ROAD,	, #201	, ROCKV	/ILLE	E, MD.	20850
LI S	tate	31. Date filed (Mooth Day, Year) 7 21	32. Agistrar's Sign	ature	nach						

ROXANNE STITZ AMICK

UNK UNK

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certif	icate of	Death		Reg	g. No.	000 300	ر ا
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)  Roxanne Stitz Amick  Roxanne Lee Amick  As Easilist Name (if not notifying any street and number)						Date of Death Month September	Day Year	3. Time of Death 0830 hrs	
and the control of th		4a Facility Name (if not institution 9906 Belair Road	i, give street and num	ber)	41	o. City, Town, or Li Kingsville	ocation of Death		4c. County of Baltimore		
Funeral Director		,		. Age (In yrs. last i		If Under 1 Year Months Days	If Under 24Hrs Hours Min.		· ·	Birthplace (State or Foreign	
		219-02-6531 Usual Residence of Decedent	1M 2X XF		40 Yrs			3/2/1	1966	Country) MD	_
w any		10a. State 10b. County	•	10c. City, Tov						10d Inside City Limi	
daryland 28a-f show	ctor	MD Balt	imore		Bal.	timore 10f. Zip Code		110	g Citizen of Wha		10
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "matural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	I Director	4214 Necker				21	236		US		
eath wit items 2	ıneral	11. Marital Status  1 Never Married 2 X Ma	rried Armed For				anic Origin? ( Spe Mexican, Puerto R		14 Race - White,	American Indian, Black, etc.	
after de	by Fun	3 Widowed 4 Divo	1 Yes rced If Yes, Give Year or Dates.	2 <b>X</b> No	1 🗌	Yes 2X No	specify:		Specify:	white	
hours. 'natur		<ol> <li>Decedent's Education (Spec Elementary/Secondary (0-12)</li> </ol>	fy only highest grade				in (Give kind of wo		16b. Kind of Bus	iness/Industry	
5-0036 tled within 72 Hygiene Jother than "	ompleted	12	College (1-	(01 01)	Ног	memaker			Res	sidence	
215-0036 be filed within 7 stal Hygiene rked other than cut, the Medica	Ö	17. Father's Name (First, Middle,				18	B.Mother's Name (F		,		
21215-( uld be filed v Mental Hygi marked oth	o Be	Albert R.  19a Informant's Name/Relationsh			19b. Mailing.	Address (Street)	Joan and Number or Ru		Leprech		-
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Meutal Hygene Important: If item 27 is marked other thingury or other traumatic event, the Med	٦	Michael E.	Amick	1	421	4 Necke	r Ave.	Balti	imore,	MD 21236	
ore, Nest and of Health If item		20a Method of Disposition  1 Burial 2 Cremation	3 Removal from	n State E.V.s	e of Disposit	on (Name of ceme er place) uneral Bel Air	sept	ember		City or Town, State	
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spe 21. Symatur of Funeral Service L		Cħář		Bel Air		2006		st Hill, MD	- 5
Balt permit Depart Impor injury		Motot O. S.	rell	6			eral Ch		Parkvil	le, MD 212	3
Physician Medical		23a. Part I Enter the disease, or of failure. List only one cause of		ised the death. Do	not enter the	e mode of dying, s	uch as cardiac or r	espiratory arre	st, shock, or hear	t Approximate Interv Between Onset an	
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	e injuries						Death	
The state of the s		Sequentially list conditions,	b	51100 <b>q</b> 401100 01).							
4	miner	if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated	Due to (or as a c	onsequence of)						43.00	
cuted transit	Exar	events resulting in death) Last	Due to (or as a c	onsequence of):							_
an an	lical	X unpended	Y AMENDED	item#1,23a,	27 282-	-f perMF a8	260 10/20/	 06. TT			
76 cate	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, or	itcome of pregnan	су				23d Date of d		
lox 68: eath certifi e attending for use as i	sician/Medical	past 12 months?	4 Pregna	th nt at time of death		al death 3 er (Specify)	Ectopic pregnand	СУ	Month	Day Year	
Box 6  he death cer  the attendi	Phys	Part II. Other significant condition	9 Unknow		ting in the un	idarluina agusa au	ron in Port I	23e Did toh	nacco uno contrib	ute to the cause of death?	
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi	þ	Part II. Other significant condition	one contributing to t	Jean Dut Hot resul	ting in the un	idenying cause giv	veri ili Fait I.			Probably 4 V Unknowr	1
ords, w requires is been seen and the	ompleted	¥						24a Was ar autops		ere autopsy findings availab ior to completion of cause of	
Reco	omo				_			perform	ned? de	eath? ✓ Yes 2 No	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?	Hospital				of Death (Check on				
n of Vi ling Physi After this funeral dii	: To	1 Yes 2 No 27. Manner of Death	28a. Date or (Month, D		/Outpatient b Time of Inj				Residence 6		
ion ( fending eath or: Al	ation	1 Natural 5 Pendi 2 Accident Invest		/15/2006 F	Ind 8:25	am 1 Ye	es 2 X No	unknown			
Division of Vital Records, pital or Attending Physician: The law require ours after death terral Director: After this certificate has been sifilled in by the funeral director, page 2 should by	ertification:	3 Suicide 6 Could	not be 28e Place	of Injury - At home		, factory, office bui	ilding, etc. 2	8f. Location (St	reet and Number	or Rural Route Number, Cr elair Road	ty
Fospita 4 hours uneral	ပ	29a. Certifier 1 Certifying Ph	ysician: To the best	woods		ed at the time date					- 1
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check of it)	niner: On the basis of and manner sta	examination and/o							H
F % F 8	Me	29b. Signature and title of certifier				29c, License				(Month, Day, Year)	
$\phi_{\rm s} c_{\ell}$		Yamu Touthe	My completed course	of death (Itam 22)	a)	O.C.M	1.⊈.		September	10, 2000	_
Or Se.		Pamela Southall, MD	Accietant Mad	ical Evaminar	111 0	enn Street, Ba	altimore, MD 2	1201			
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Re	strar's Signature	K AD	edi					

06-06984 Anthony D. Adams

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	_	ertificate of l	Death	R	eg No	100 300
Physici Medical Exam			nony D.	Adams		Date of Dea     Month		3. Time of Death 1538 hrs
		4a Facility Name (if not institution, give Johns Hopkins Hospital	street and number)	1	City, Town, or Location of Baltimore	Death	4c. County of De	eath
Funeral Director			7. Age (In yrs	s. last birthday)  25 Yrs.	If Under 1 Year If Under Months Days Hours	Min		Birthplace (State or reign Country) N.C.
nd show any	_	Usual Residence of Decedent  10a State 10b. County  Md . NA	10c. C	ity, Town or Location				10d Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number  2024 E. North Ave	2.		Of, Zip Code 21213	1	0g Citizen of What C	country?
ter death wi	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No No Decedent Ever in Armed Forces?	If Yes	Decedent of Hispanic Origin specify Cuban, Mexican, F es 2 V No specify	n? ( Specify Yes or No Puerto Rican, etc.)	White, etc	nerican Indian, Black, c. B <b>lack</b>
= <sup>2</sup> 2 0	Completed b	15. Decedent's Education (Specify on Elementary/Secondary (0-12)  12th grade	or Dates: y highest grade completed) College (1-4 or 5+)		Usual Occupation (Give kill of working life DO NOT un		16b. Kind of Busines	
오동하네	Be Corr	17. Father's Name (First, Middle, Last)  Johnny	Clinton	<u></u>		Name (First, Middle, I	Maiden Surname)	Adams
MD 21 nd 2 should alth and Mer im 27 is man	P	19a Informant's Name/Relationship (Ty Shirley Hooker 20a Method of Disposition	pe, Print)  Mother	19b. Mailing A	ddress (Street and Numb E. North Ave	er or Rural Route Nur nue, Balti	nber, City or Town, St.	ate, Zip Code) 21213
Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the J		1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Service Licens	Removal from State	orematory or other Mt. Carme	l Cem.	Date 9 <b>–22–</b> 06	20c. Location - City  Dundalk,	
Balti permit Departri Imports injury o		23a. Part I. Enter the disease, or compli	Worrer	$\geq$ 11	one and Address of Facility  Ol E. North  mode of dying, such as car	March F. Ave., Balt	imore, Md.	. 21202 Approximate Interval
/Medical Examiner	7	failure. List only one cause on eac Immediate Cause (Final disease a	h line. <b>langing</b> ue to (or as a consequence					Between Onset and Death
	iner	cause. Enter Underlying Cause	ue to (or as a consequence	of):				
executed an and all - transit	al Examiner	d	ue to (or as a consequence	of);				
ੂ ਜ਼ੜ੍ਹੀ	n/Medical	UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the	AMENDED  23c. If yes, outcome of pre		death 3 Ectopic p		23d Date of deliver	
Box 68	Physiciar	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time of a Unknown	death 5 Other	(Specify)		Month	Day <b>Y</b> ear
IS, P.O. quires that then signed by all be detach	ð	Part II. Other significant conditions	contributing to death but not	t resulting in the und	erlying cause given in Part	1 Yes	2 <b>V</b> No 3 Pr	to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Completed					24a Was a autop perfor	sy prior to med? death?	
f Vital F Physician: rr this certifical	To Be	25. Was case referred to medical examiner?  1 V Yes 2 No  27. Manner of Death	spital: 1 Inpatient 2	ER/Outpatient 3		lursing Home 5	Residence 6 🗸 Oth	ner: Scene
Division of tall or Attending Press after death.  al Director: After led in by the funeral	Certification:	1 Natural 5 Pending 2 Accident Investigation		28b. Time of Injur	y 28c. Injury at Work?  1 Yes 2 ✓ N  actory, office building, etc.	Subject han		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		3 Suicide 6 Could not be determined 4 Homicide Certifying Physicia	(Specify) Police Start: To the best of my knowle	ation		or Town, Si 1620 Edison	<sup>tate)</sup> Highway, Baltin	
To the Hospital within 24 hours To the Funeral completely filled	Medical	one) 2 Medical Examiner:						the cause(s)
1		30. Name and address of person who co	AULUM— mpleted cause of death (Ite	m 23a)	O.C.M.E.		September 18,	
St	ate		Medical Examiner	111 Penn Str	eet, Baltimore, MD 2	1201		
Regist	rar	SEPAALO	January 1	d				

06-07023 Andre Aldridge

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Cer	tificate of Death		Reg. No	0 3007
Physician Medical Examine	1. Decedent's Name (First, Middle,L		dridge	2 Date of Month Septen	Death Day Year nber 17, 2006	3. Time of Death 1545 hrs
	4a Facility Name (if not institution, 1013 North Woodington		4b City, Town, o	or Location of Death  City	4c. County of Death	
Funeral Director		Sex         7. Age (In yrs late)           XM         2         F         49	Months Da	ve Hours Min	Foreign	nplace (State or n ntry) <b>Md</b> .
á:	Usual Residence of Decedent  10a. State 10b County	I10c. City	Town or Location	<del></del>	·	10d Inside City Limits
vlaryland 28a-f show any Latonce.		NA I	Baltimore			1 X Yes 2 No
th the Maryland  23a or 28a-f sho  uotified at once	10e. Street and Number		10f Zip Code		10g. Citizen of What Coun	try?
ith the 123a or 101ffe		gton Rd.  12. Was Decedent Ever in U.	212:	29 Ispanic Origin? ( Specify Yes o	USA r No- 14. Race - Americ	an Indian Black
i, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Marenal Hygiers of the matural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Re Commissed by Eringeral Director	1 Never Married 2 Married 3 Widowed 4 X Divorce	A   F 0		an, Mexican, Puerto Rican, etc.)		
ours aft atural" kamine	15 December Education (Consist	or Dates.	16a Decedent's Usual Occup.	ation (Give kind of work done	16b. Kind of Business/Ir	
5-0036 ed within 72 hours at tygiene other than "natural the Medical Examin	Elementary/Secondary (0-12)  12th grade	College (1-4 or 5+)  2 yrs.	during most of working lif		Theater	
21215-0036 uld be filed within 7 Mental Hygiene marked other than e event, the Medica		·		18 Mother's Name (First, Midd	lle, Maiden Surname)  Aldridge	
2121; Mental be fil marked ic event, i		Rice (Type, Print)	19b. Mailing Address (Stre	Ruth eet and Number or Rural Route		THE SALE OF THE SALE OF
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 ni of Health and Mantal Hygiers other traumatic event, the Medical TO Be Commiss	Ruth A. McLean  20a. Method of Disposition	Mother	1013 N. Woo	odington Rd., I		
5 2 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	1 X Burial 2 Cremation	Removal from State	crematory or other place)		20c. Location - City or T	
Baltimo permit Page Department of Important: injury or ott	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic	·y.	butus Mem. Pk. 22 Name and Addres		F.H. East	ria.
	23a. Part I. Enter the disease, or co	Warren		North Ave., Ba		21202
Physician /Medical	failure. List only one cause on	each line.		ra	r arrest, snock, or neart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	a Hypertensive ather Due to (or as a consequence of		vascular dis ase		
ž	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	·).			
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of	·):			7
executed an and al - transit		d				
	IF FEMALE:	#23a,PII,	27,28a-f, perME, (	G863, 1/19/07 TT	23d. Date of delivery	
Sox 6876 leath certificate e attending phy for use as the I	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of dea	2 Fetal death 3 ath 5 Other (Specify)	Ectopic pregnancy	Month Da	ay Year
). Box 68: The death certification by the attending sched for use as I physician.	1 Yes 2 No 9 Unkno	wn 9 Unknown	J Other (Specify)			
ires that the signed by I be detach	Complication of	-	esulting in the underlying cause		Yes 2 No 3 Proba	
Records, The law requires fricate has been sig. page 2 should be		<u> </u>		24a V		opsy findings available impletion of cause of
tal Reco				P	erformed? death? es 2 No 1 Ves	
Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical examiner?	Hospital 1 Inneticet 2		Other Nursing Home 5	Desidence of double	0
ing Phys After thii	27 Manner of Death	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 DOA  28b Time of Injury 28c Inj	L	Residence 6 Other	Scene
sion ttendir death. ztor: A y the fu	1 Natural 5 Pending 2 Accident Investig	E-1 1007	unk.	Yes 2 No unk.		
Division of Vital Records, pital or Attending Physician: The law requir was after death.  erral Director. After this certificate has been s filled in by the funeral director, page 2 should 1 Contification. To Re Completor	3 Suicide 6 X Could n determi	ot be	ome, farm, street, factory, office		on (Street and Number or Run in, State)	al Route Number, City
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burification: To Reformulated by Physician/Medicial		ician: To the best of my knowledger:On the basis of examination ar		date and place, and due to the		
To To To Marit	29b. Signature and title of certifier	and manner stated.	29c. Licer	se number	29d Date signed (Mon.	h, Day, Year)
	Amen Dourthay	(m)		.M.E.	September 18, 20	06
\$	30 Name and address of person with Pamela Southall, MD	o completed cause of death (Item Assistant Medical Examir	ner 111 Penn Street,	Baltimore, MD 21201		
Stat Registra		2006 32. Fingustrar's Signatu	5 Sparker			

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of rtificate of			giene 200	6 30099
	Physici /Medic		<ol> <li>Decedent's Name (First, Middle, Las Rose Marie Broade)</li> </ol>	,				2. Date of De Month	Day Yea	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Union Memorial Hos	spital			timore	Death	4c. County of De	/A
	Funeral Director		5. Social Security Number 6. Sec. 1  220–14–8536  Usual Residence of Decedent	M 2⊠F 7. A	ge (In yrs. last birthday, 89 Yrs.	Months Day		Min. (Month, Da	th, Year) 9. E 3,1917 Ba	Birthplace (State or Foreign Country) 1timore, MD
	Be-f show	ctor	10a. State 10b. County  Maryland N/A	A	10c. City, Town or L Baltimor					10d. Inside City Limits 1 ②Yes 2 □ No
	23a or 24	rai Director	10e. Street and Number 1350 Weldon Ave.		-		21211		10g. Citizen of What United S	tates
036	ei', or item	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 22 If Yes, Give Year or Dates:	? 1 No	Was Decedent of If Yes, specify Cu		in? (Specify Yes or No Puerto Rican, etc.)	2	mencan Indian, hite, etc. White
Maryland 21215-0036	s i and 2 should be lied whim / 2 hours after death with the Maryland and all had Mental Hygiene. I shall had Mental Hygiene. I shall shall be a shall be	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed) College (1-4or N/A	5+) (Give	dent's Usual Occi kind of work don DO NOT use retir	e during most o	of working	16b. Kind of Busines Hutzler B	ros./
land 2	and Mental Hygie and Mental Hygie marked other i	To Be Co	17. Father's Name (First, Middle, Last) Bernard Sauer	IV/ A	ASS	istant E	18. Mother	s Name (First, Middle Geyer		part.Store
, Mary	and z should be lealth and Mental m 27 ie marked ( her traumatic ev		19a. Informant's Name/Relationship (7 Mrs. Patricia A. I		ughter) 61	.09 Dunro	et and Number	or Rural Route Numb Dad Balt	er, City or Town, State imore, Mary	land 21239
altimore,	ntment or range right or right or right.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signaturary Funeral Service Licen:	)	Evans Fun	matory or other pl eral Cha	pel Se	- 412		ill, Maryland
Ba	Depa Impo		23a. Pawl. Enfer the disease, or compshock, or heart failure, usst only company.	F. Jai	23	25 York	Road	Timonium,	Maryland	ion Ctr., P.A. 21093
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aA	NO XIC	BRAII	VIN	Jury		Interval Between Onset and Death
Box 68760, C	physician and minial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of):	ENSI	ON			30 Years
.O. Box 68	e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 ☑ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of d Month	elivery Day Year
ecords, P.O	been signed t	þ	Part II. Other significant conditions co	ntributing to death I	but not resulting in the u	nderlying cause g	iven in Part I.			lo the cause of death?  Probably 4 Monknown
I g	page	Completed							an 24b. Were a prior to death? 22 No 1 \(\sumeq\) Ye	autopsy findings available o completion of cause of
of Vita	certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:		10	ther	f Death Check only o		
	After	ation: To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time o	28c. Inju	4 🗆 14u15	28d. Describe t	dence 6 Other (Sp now injury occurred	ecify)
= 2	1 th 1 th	Certification:	3 Suicide 6 Could not be determined	building, e	ijury - Al home, farm, str tc. (Specify)			City or Tov		1
To the Hoenital	hin 24 hou the Fune mpletely fil	Medical	one)	sician: To the best iner: On the basis of and manner st	t of my knowledge, death of examination and/or in tated.	vestigation, in my	opinion, death	occurred at the time,	date and place, and du	ue to the cause(s)
Ę	TW T			ne, M.D.		AT2	138946		Septembe	v 20,2006
	Le		30. Name and address of person who c	OMIC	death (Item 23a) (Type,	Print)	Mema	RIAL HI	ospital.	MD
3	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	s Signature	Specie	,			

Physician	State of Maryland / D  1 - State Amend #19a&b&20c Per INF G860  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Date of Death     Month Day Year	
/Medical	FRANCES A. BROWNING		September 20, 20	006 3:30 P <sup>M</sup>
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
Funeral Director	Greater Baltimore Medical Center   5. Social Security Number   6. Sex   7. Age (In yrs. last birth   213-20-8277   1 □ M ※ XX   81   N	TOWSON  If Under 1 Year II Under 24 Hrs.  Months Days Hours Min.	Baltimo 8. Date of Birth Dec. 3, 1924 Mar	irthplace (State or Foreign
dand and	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location		10d. Inside City Limits
S Maryl e Maryl ta-1 eho	MD Baltimore	Parkville		1 □ Yes <b>X</b> IXNo
WCES H death with the Maryland ms 23s or 28s-1 show mult be notified at	10e. Street and Number 2500 Windsor Road	10f. Zip Code 21234	10g. Citizen of What C USA	Country?
AHMCES 336 us after death with the Ma ii, or theme 23a or 28a-1 e confiner must be notified	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  1 Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto F	crify Yes or No- Rican, etc.) 14. Race - An Black, Wr Specify:	nerican Indian, nite, etc. White
72 ho 72 ho dicall		Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)  Sales Person	16b. Kind of Busines Retail	•
Maryland 2121 Maryland 2121  M2 should be filed within the and Mental Hygiene.  27 is marked other than traumatic event, the Maryland to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Compiled the standard to Be Standard	17. Father's Name (First, Middle, Last) Nereus W. Gunther		(First, Middle, Malden Sumame)	
Mary Mary and 2 sho ealth and 1 m 27 le m	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Lawrence Browing - spouse  Browning 25	Mailing Address (Street and Number or Rura 000 Winder Road-Pa Windsor		
Baltimore Sernit. Pages 1: Separament of He mportant: If item ny joliury or oth	1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	7000 Cemerelery 9-2	20c. Location - City of Parville, Parkville	or Town, State , Maryland
Ball permit Depar Impor Impor	21. Signature of Funeral Service Licensee	22. Name and Address of Facility EVA 8800 Harford Roa	NSPCHAPEL18F, M	MEMORIES aryland21234
Physician /Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the cause of the	with Muttiorgan Sys	- 1	Approximate Interval Between Onset and Death 2 days
Examiner	Tool	Bowel		Iweek
Box 68760, Seath certificate be executed attending physicien and for use as the burial-transit	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or	heroembolism		3 weeks
rilicate ng phys as the	IF FEMALE:			
Division of Vital Records, P.O. Box 6876 or Attending Physician: The law requires that the death certificate be after death.  Increase:  Increa	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of do Month	elivery Day Year
Cords, P  # requires that been signed be should be deta		the underlying cause given in Part I.	23e. Did tobacco use contribute  1 Yes 2 No 3 F	
f Vital Record yeiclen: The law requir is certificate has been si director, page 2 should			performed? death?	autopsy findings available completion of cause of as 2 \sum No
Vital F siclen: Th certificate rector, pag	25. Was case referred to medical examiner?	26. Place of Death		
on of \ value of physical directions of tuneral directions of tuneral directions. To	27. Mann of Death 28a. Date of Injury 28b. Ti	patient 3 DOA 4 Nursing Hom	ne 5 Residence 6 Other (Sp 8d. Describe how injury occurred	ecify)
Division of To the Hospital or Attending Ph within 24 hours after death. completely filled in by the tuneral	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, land building, etc. (Specify)	m, street, factory, office	81. Location (Street and Number or P City or Town, State)	Ru <i>ral Route Number,</i>
Dji s the Hospital or in 24 hours afte mpletely filled in 1 Medical Cert	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, and manner stated.	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	nd due to the eause(s) and manner a d at the time, date and place, and du	us stated. ue to the cause(s)
vithin 2 To the within 2 To the complet	29b. Signature and title of contriber	29c. License number	29d. Date signed (Mor	nth, Day, Year)
	Je Moluehe M.D.	D25349	9/21/0	06
5	30. Name and address of person who completed cause of death (Item 23a) (	IV. Charles St. To	1000 1001 111	No.
, J	Peter Golveke M.D. 6565	IV. I MULIPE 34 IN	N 50 M WINE W. 1.	107

			1 - For State Registrar	State of Ma	-	artment of F <i>rtificate of</i>		, ,	iene <b>c u</b> u ( eg. No.	5 50101	
	Physici	an	1. Decedent's Name (First, Middle, La	•				2. Date of Deat Month	h Day_ Year	3. Time of Death	
	/Medic		Donna Jean Bing					Septemb	er <sup>Day</sup> 20, 200		
	Examir	ier	4a. Facility Name (If not institution, giv	e street and number)			or Location of Death		4c. County of Death		
			11204 Beach Road 5. Social Security Number 6. S	ον 7 Δαι	e (In yrs. last birthday)	White M		9 Date of Rieb	Baltimo		
	Funeral Director			☐ M 2[XF	36 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, OCt. 03,	1969 Mai	rthplace (State or Foreign Country) ryland	
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Mary	to	Maryland Baltimor	e	Rossvill	le				1 ☐ Yes 2 🔯 No	
	th the	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What C	Country?	
	death with the Maryland ms 23s or 28e-f ehow fintert or notified at	ai	4 King Richard Co	ourt		2123	7		U.S.A.		
-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic event. The Medical Experient runtal be notified at	by Funeral Director	11. Marital Status  1 ঐNever Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ło	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W		
รุ	2 hot		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	oation		16b. Kind of Business		
2 7 7	hin 7	Completed	(Specify only highest gra	ide completed) College (1-4or 5	(Give	kind of work done DO NOT use retire	during most of worki d)	ing			
-	e filed within at Hygiene. I other than 'vent, the Me	Son	12			ng Clerk			Port Admin	nistration	
yland	be fill d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name		faiden Sumame)		
	2 should be and Mental le marked aumatic ev	ဥ	Danny Bingamon				Frances 1				
Mai	d2 st th and 7 te m traum		19a. Informant's Name/Relationship (	** *					City or Town, State, aryland 2°		
ف -	1 and 2 Health tam 27 other tru		Lora Halterman (S	ister)	20b. Place of Dispo		100 000		20c. Location - City o		
5	ages int of t: If it		1X Burial 2 ☐ Cremation 3 ☐		cemetery, crei	matory or other plac	ce)				
Баптато	permit. Pages Department of I Important: If Its any Injury or of		4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer		Holly Hil				altimore,		
מ	permi Depa Impo any Ir	6	1			40 / O1a .	Eastern A	venue, E		A. yalnd 21221	
	Physician		23a. Part1. Enter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each in	the death. Do not entie.  ARCINOMA				st,	Approximate Interval Between Onset and Death	
	/Medical		resulting in death)		a consequence of):	Of Cioria	XUIV FRIT	VAR Y		9 months	
	Examiner		Sequentially list conditions.	b							
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):						
,	and and II-tran	Examiner	that initiated events resulting in death) Last	c	a consequence of):						
0/00,	tificate be executed g physicien and as the burial-transit				,						
000	g phy as the	edicai		d							
.O. DOX	To the Hospitel or Attanding Physicien: The law requires that the death certificate be executed within 24 hours eight death. To the Funeral Director: Attenthis certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 1 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	olivery Day Year	
r (n)	quires that in signed b	ρ	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the u	nderlying cause giv	en in Part I.	1		o the cause of death?	
	The law re ete hes bee page 2 sho	Completed						24a. Was an autopsy perform	prior to eath?	utopsy findings available completion of cause of	
יום	cian: ertific actor,	Be	25. Was case referred to medical examiner?				26. Place of Death				
5	Physi this c al dire	2	1 Yes 2 No	Hospital: 1 ☐ Inpatier			4 Li Nursing Hor		nce 6×10x10ther(Spe	sch Sister Snoe	
5	ding l. After funer	ioi	27. Manner of Death  1. Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	Wor		28d. Describe hov	w injury occurred		
2	deatl deatl ctor: y the	fical	2 Accident investigation 3 Suicide 6 Could not be		ry - At home, farm, str		Yes 2 □No	28f Location (Stre	eet and Number or R	ural Pauta Number	
2	efter Dire	Certification;	4 ☐ Homicide determined	building, etc	. (Specify)	eet, ractory, ornoe	1	City or Town,	State)	urai noule ivuriber,	
	Hospite 24 hours Funeral etely filler	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best on tiner: On the basis of and manner states	examination and/or in-	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)	
	ompl	Me	29b. Signature and title of certifier	>		29c. License	e number	29	d. Date signed (Mon	th, Day, Year)	
			Dein Hung			3-515	555	00	9/20/20	06	
	Q		30. Name and address T person who	completed cause of de	eath (Item 23a) (Type,		1 7	14	7/20/20 MD 213	137	
P	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	200	V. DG	10.	40 010		
9	Registra	ar	SEP 2 2 20	06 paren	JA AD	assi					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 7:20 AM M Doris Bodine 09 19 2006 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Towson, Maryland
If Under 1 Year | If Under 24 Hrs. | 8.
Months | Days | Hours | Min. | 8. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Yrs. 86 153-01-6429 12/22/1919 New Jersey Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director MD Baltimore Towson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Dulaney Valley Road 21204 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assistant Manager Banking Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Ware Bernetta Mason 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Green Glade Road - Phoenix, Maryland Warren Oler 21131 (P.O.A.)20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) 09/22/2006 Camden, New Jersey Harleigh Cemetery 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland assahn Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Exist in Jordan Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

al Hygiene.

Be

permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event <u>2002</u>.

SEPTEMBER

Baltimore,

Box 68760

Records, P.O.

of Vital

Division

DORIS BODINE

with the Maryland

72 hours after death

use as the burial-transit attending physician and Completed by Physician/Medical ۵ should l has certificate Attending Physician: Be ဥ this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of Certification:

autopsy performed?

26. Place of Death Check only one Other: 4 💆 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes 2 ▼ No

27. Manner of Death

1 X Natural 2 ☐ Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

9/20/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

State Registrar

3

SEP 2 2 2006

5 Pending investigation

6 Could not be

32. Registrar's Signature

		4	For State Registrar	State of M	Maryland / Dep Ce	partment of Fertificate of	lealth and Death		iene 2 0 (	30103
	Physici	an	Decedent's Name (First, Middle     James Michael					2. Date of Deat Month Sentemb	er 21,20	3. Time of Death
	/Medio	- 4	4a. Facility Name (If not institution		or)	4b. City, Town, o	r Location of Deat		4c. County of	
- 0	LXaiiiii		900 Martell C	Court Act.	G	Be.	l Air		Hai	rford
Đị,	Funeral Director	1	5. Social Security Number 215-07-3204		Age (In yrs. last birthda) 92 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Apr. 3,	Year)	9. Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Limits
	n the Marylans r 28a-f show motified at	į.	Maryland Harfor	rd.	Bel Air					1 ☐ Yes 2 🔯 No
	or 288	lrec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
\	ath wi	rai	900 Martell Co			21014			USA	
21215-0036	d within 72 hours after death with the Maryland Jiene. r then "natural", or items 23a or 28a-f show The Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri  3 ♥ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1  Yes 2  If Yes, Give Year or Date:	∑No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2  No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		· American Indian, White, etc. White
5-0	72 ho	Completed	15. Decedent (Specify only highes	t's Education at grade completed)	(Giv	edent's Usual Occup	during most of wo	rking	16b. Kind of Busi	ness/Industry
121	within then "	mpi	Elementary/Secondary (0-12)	College (1-40	or 5+)	DO NOT use retired	,			re County
d 2	il Hygiene. other then vent, the M		17. Father's Name (First, Middle,	Last)	Supe	rvisor Ass		me (First, Middle, M	Governme Maiden Sumame)	
lan	should be ind Mental marked o	To Be	Joseph Patrick	Barry			Winifre	ed Veroni	.ca Neary	7
Maryland	O1 10 - 10		19a. Informant's Name/Relations	hip (Type, Print)	10000	ling Address (Street				56
a)	0 0		James C. Barry/ 20a. Method of Disposition 1 XBurial 2 ☐ Cremation		20b. Place of Disp	Martell Co position (Name of rematory or other place		G, Bel	Air, MI 20c. Location - C	D 21014 ity or Town, State
ţ	permit. Pages Department of I Important: If Ite any injury or or once.		4 ☐ Donation 5 ☐ Other (S)	pecify)	1 Bel Air	Memorial	Grdns.	9-26-06	Bel Air,	Maryland
Ba	permit. Pag Department Important: any injury o		21. Signature Funer Service	Emy 1		Name and Address I McComas I 1317 Coke	esbury Ro	bad, Abin	gaon, Ma	aryland 21009
9 % 6%			23a. Part1. Enter the disease, or shock, or heart failure. List							Approximate Interval Between Onset and Death
5	Physician /Medical	П	Immediate Cause (Final disease or condition resulting in death)	- a Ather	20 selenot	ic CARd	10VASCU	LAR di	TEASE	ten years
1	Examiner			Due to (or a	as a consequence of):					
, E		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of):					
$p_{D}$	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of):					
8760,	be exicien burial			540 10 (0)	as a consequence on.					
687	ificate I g physi as the t	edic		d.					_	
P.O. Box	or Attending Physician: The law requires that the death certificate be executed interdeath. Director: After this certificate has been signed by the attending physicien and Director: After this certificate has been signed by the attending physicien and in by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	☐Ectopic pregnancy	<i>'</i>		23d. Date Monti	
Vital Records, P.	uires that the signed by the detaction	þ	Part II. Other significant condition	ns contributing to death	n but not resulting in the	underlying cause giv	en in Part I.		_	ute to the cause of death?
00	s been should	Completed						24a. Was a	n 24b. We	ere autopsy findings available
Re	The lav	шо						autops perform	ned? de	or to completion of cause of ath?  Yes 2[XNo
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					ath (Check only on		
of V	Physic this ce al dire	ို	1 ☐ Yes 2 No	Hospital:			4 U Nursing F	dome 5 Reside		
UC C	ding F	ilon:	27. Manner of Death  1 Natural  5 □ Pendin investig		njury 28b. Time Day Year) Injury	Wor	yat k? Yes 2 ⊡No	28d. Describe ho	ow injury occurred	3
Division	Attendition of the formal of t	Certification:	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place of	Injury - At home, farm, s					or Rural Route Number.
á	s after	Certi	4  Homicide	building,	etc. (Specify)			City or Town	n, State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the be Examiner: On the basis and manner	of examination and/or	investigation, in my o	pinion, death occi	urred at the time, di	ate and place, an	d due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	- A		29c. Licens	e number	2	9d. Date signed (	(Month, Day, Year)
3			Mul	While	UD	d	3552	. 2	extemb	er 21, 2006
_	12		30. Name and address of person MARL W	ILL 2	NORTH J	e, Print) AVENUE	BEL A.	IR M	4RYLA	Month, Day, Year)  PR 21, 2006  Vd 21014
**************************************	Sta Regist		31. Date liled (Month, Day, Year)	2 2006 32. Segi	strar's Signature	parti		-		•

			Type or Print in				•	-	
		1 - For Amend #1,	State of Maryla 18&20b&c Per	and / Department Phy &th 859 Centificati	te of Deal	and Menta h	l Hygier Reg. i	re2006	30104
Phys	ician	1. Decedent's Name (First, Middle, Las	st)	D 1 2 D		2 Dat	e of Death	Day Year	3. Time of Death
/Me	dical	Lodney Darv  4a. Facility Name (If not institution, give		1 1	, Town, or Location	PEPT	GNAGK	18 300 4c. County of Deat	
Exan	illier	GOOD SAM A	RITAN HO	SPITAL	BAZTIA	rone		N	A
Funera Directo	200	76.11.0121		75. last birthday) If Under Months		s Min. 8. Dat (Mo	e of Birth nth, Day, Yea	9. Birtl	hplace (State or Foreign untry) MD
Maryland	jor	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Location  Baltimor	re				10d. Inside City Limits 1 X es 2 □ No
lore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other then "natural", or items 23a or 28a-1 ehow or other traumatic event, the Medical Examinar must be notified at	i Director	10e. Street and Number 1534 Ramblew	ood Road		2123	,9	10g. (	Citizen of What Co	untry?
er death Itema 2	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Dece	dent of Hispanic orfy Cuban, Mexi	Origin? (Specify Ye can, Puerto Rican,	s or No- atc.)	14. Race - Ame Black, White	ncan fndian, e, etc.
3036 Sours aft Jraff, or	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🜠 No If Yes, Give Year or Dates:	1 🗆 Yes	25€ No Spec	ify:		Specify: B	ack
215-( 215-( nin 72 h in "natu Medice	Completed	15. Decedent's Ec (Specify only highest gra		16a. Decedent's Usu (Give kind of wo life. DO NOT u		nost of working	16b.	Kind of Business/I	
d 212 filed with Hygiene ther the		Elementary/Secondary (0-12)  2+h QVa(le  17. Father's Name (First, Middle, Last)		life. DO NOT L		(5)		1000	<b>t</b>
arylanc should be fi nd Mental b marked of	To Be	Ahave Brown			2°	Styn Bu		Roslyn L	ee
Maryland 21215-0036 at 2 should be filed within 72 hours aff the and Mental hygiene. The marked other then "natural", or traumatic event, the Medical Exertition of the stantial control of the marked other then "natural".		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing Addres	1 1	. 0		y or Town, State, Z	
ore, N es 1 and of Health filtem 27		20a. Mathed of Disposition  1 Burial 2 Cremation 3	Removal from State 20t	Place of Disposition (Na	MbleW01	od Koad		dsof Mil	
1 2 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		4 □Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	)	N <i>estem Len</i>	<del>1<i>e</i>+en</del> )	09/23/	16 1	allimore	MD
Balt permit. Depertri Imports eny inju		130 Clay	+	Vougu 4905	VOIL RO	ne Funera ad Baltim	u servi	21212	
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	eath. Do not enter the mor	ae or dying, such	as cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
Physician /Medica	i	disease or condition resulting in death)	a. CONCESTI Due to (or as a cons		TFF	ALLURE			
Examine	er	Sequentially list conditions, if any, leading to immediate	b. Seurar	DILAZZ-D	CARDI	myopi	ATHY		
<b>6U,</b> be executed icien and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					17	
		resulting an death) cast	Due to (or as a cons	sequence of):					
EOX 68 / 6U, eath certificate be exattending physicien for use as the buria	Medic	IF FEMALE:			Andrew Control		820		
. 5 . 5	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Find the constant of the constant in the con	etal death 3 □Ectopic p				23d. Date of deli Month	very Day Year
- E D 0	by Ph	Part II. Other significant conditions co					. Did tobacc	o use contribute to	the cause of death?
VITAL HECOYGS, itcien: The law requires to certificete has been signes fector, page 2 should be of	eted	MORBID OBES	174 (=6	100 Ubs in	the pa		1 ☐ Yes		obably 4 Unknown
I KEC The law ete has b page 2 sl	Completed						autopsy performed? Yes 2 1	death?	topsy findings available ompletion of cause of
	Be	25. Was case referred to medical examiner?	Hospital:	- /	Ott	ace of Death   Check	only one)		
Phy ratio	on: To	1 Ses 2 No  27. Manner of Death  1 Natural 5 Pending	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injury at Work?	Nursing Home 5 [ 28d. De		6 Other (Spec	nfy)
tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be		M thome, farm, street, factor	1 ☐ Yes 2		ation (Street	and Number or Ru	ral Route Number
rs after ref Dire	Certi	4 Homicide determined	building, etc. (Spe	ecify)		City	or Town, Sta	16)	
Hospital or At 24 hours after 6 Eunerst Direction by filled in by	edical	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam and manner stated.	knowledge, death occurred ination and/or investigation	at the time, date i, in my opinion, d	and place, and due leath occurred at the	to the cause time, date a	(s) and manner as and place, and due	stated. to the cause(s)
To the twithin 24	Me	29b. Signature and title of centifier	ATTEND	'' "}	c. License numbe	_		Date signed (Month	
7		30. Name and address of a r on who o	PHYSIC (		0062	17AL	SEP	TEMBER	. 19 2006
0					HOSP	TAL,	BAL	TIMOR	₹€
S Regis	tate trar	31. Date filed (Month, Day, Year)  SFP 2 2, 20	06 32 Pegistrar's Sig	MARITAN Inature	•				

			For State Registrar	State of	Maryland		ırtmen <i>tificat</i>			and M		giene Reg. No.2	106	30105
	Physici		Decedent's Name (First, Middle, I Joseph Lynn Cla						Manth Day Your		3. Time of Death 4:25 A M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Joseph Ritchey Hospice				4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A				
	Funeral Director		5. Social Security Number 213-36-2934	Sex 7 1 M 2 □ F	. Age (In yrs. Ia 64	st birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir NOV • 1	9, Year 1941	9. Births	olace (State or Foreign Try Land
	pue 🗼		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					-	1	0d. Inside City Limits
	Maryl sho	ioi	MD Bal	timore		В	altim	ore						1 ☐ Yes 2 🛱 No
	death with the Marylend me 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 2406 Tionesta R	oad			10f. Zip	2:	1227				ited	States
036	a ≥ 8	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1	: <b>45</b> ? ?∰No		Was Deced f Yes, spec 1 ☐ Yes	57	panic Ori Mexican Specify:	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	Spec	ace - Americack, White, ify: Wh	
4 , 2 $S$ $A$ $m$	ithin 72 ho ne. nen "netur nedicel	Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-	4or 5+)	16a. Deced (Give life.	kind of wo DO NOT u	rk done du se retired)	urina mos	t of worki	ng	16b. Kind of		
0 2 P	filed w Hygler other tl	e Co	17. Father's Name (First, Middle, La	ist)		-	Roc	ofer	18. Mothe	er's Name	(First, Middle	, Maiden Suma		ction
()	Mental Mental arked attc ev	To B	Michael Edward									erine (		
Mar	id 2 sho lth and 27 is m	r i	19a. Informant's Name/Relationship Barbara Metcalf		on		_					er, City or Town		o Codej
ore.	es 1 end 2 of Health of If item 27 i		20a. Method of Disposition	□Removal from S	IAIA	ace of Dispo metery, crei			,		Date	20c. Location		
Saltimore.	permit. Pages Depertment of h Importent: If ite eny injury or of page.		4 Donation 5 Other (Soc 21. Stantum 2 Puneral Service)	city)	Loud	lon Pa						_Baltin uneral		
	Permit Pe		Dell May	Jest Marie	H MOI	2/1	328 8	Sulph	ur S	pring	g Rd.,	Arbutus		21227
6	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											
- 1	Examiner	پ	Sequentially list conditions	b. Que to (r	or as a consequ	ence of):			•					
o.	be executed sicien and burial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
3876	ficate be physici s the bu	edical		d										-
() O. Box 68760.	the de	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Fetat unt at time of de	death 3[	⊒Ectopic p ⊒ Other (s						ate of delive	Pery Day Year
A Sp	uires thet to signed by Id be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown				
CLAR	The law requiresteen some been some page 2 should	Completed									24a. Wa auto peri 1 ☐ Yes	ormed?	o. Were aut prior to co death? 1  Yes	opsy findings available ompletion of cause of 2 No
Vital	sician: Th certificete irector, pag	Be	25. Was case referred to medical examiner?  1   Yes   2   No											
A Policy	ding Phys h. After this funeral di	ion: To	27. Manner of Death 1 ②Natural 5 ☐ Pending	28a. Date o (Mont)		28b. Time o Injury		28c. Injury Work	at			how injury occ	urred	1,027
5E	: <b>5</b> € 5 :=	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)								ral Route Number,			
3	To the Hospital or within 24 hours effe To the Funeral Director Completely filled in It	Medical C	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Check only one)  Check only one)  Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within 2	Med	29b. Signature and title of certifier				29	c. License	number			29d. Date sig		
			> 2 180 L	D		00-1 7	Delini	1)21	117	0		Septe	mber	20,2006
	3 3		Elso MD K	the completed cause	pice o	838	N.E	utav	u St	- 1	3altin	nore f	ID 2	1201
	St Regist	ate trar	31. Date filed (Month, Day, Year) SEP 2	2 2006 32. F	odstrar's Signa	ture	best	6						

06-07051 John Chandler

# Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

omi onanciei		I- For State Registrar	e of ivial yland / 1		ate of Death		Re	g. No. 200	6 3010		
Physicia Medical Exami		Decedent's Name (First, Middle, L.  Toba	ast)	Chan	flor			2. Date of Death Month Day Year September 18, 2006  3. Time of Death 0857 hrs			
neulcai Examii		John 4a. Facility Name (if not institution, g	Cilain		n, or Location of		4c. County of Deat				
		Mercy Hospital  Baltimore  NA									
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min							24Hrs 8 Date of Birt	1=			
Director	L		<b>X</b> M 2 F	34	Yrs.	Days	09-25	5–1971 <sup>C</sup>	ountry) Md.		
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits									
<u> </u>	٦	Md. N	IA I	В	altimore				1 X Yes 2 No		
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Co	de	10	g Citizen of What Cou	untry?		
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.		1222 E. Belveder	e Avenue		2123	9		USA			
th with	Funeral	11. Marital Status  1 X Never Married 2 Marrie	12. Was Decedent Ev Armed Forces?	ver in U.S.			n? ( Specify Yes or No- Puerto Rican, etc.)	14 Race - Ame White, etc.	rican Indian, Black,		
ter dea			1 Yes 2 and If Yes, Give Year	ΧNο	1 Yes 2 X	No specify		Specify: Bl	.ack		
hours afte "natural", Examiner	Be Completed by	15. Decedent's Education (Specify	or Dates:	eted) 16a.	Decedent's Usual Occ	cupation (Give kir		16b. Kind of Business			
6 172 hc an "na		Elementary/Secondary (0-12)	College (1-4 or 5+)	)	during most of working  Disabled	g life. DO NOT us	se retired)	NA			
15-0036 filed within 72 I Hygiene ed other than " t, the Medical I		12th grade  17. Father's Name (First, Middle, La	eth		DISabled	18 Mother's	Name (First, Middle, M				
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica		Early	David	Cha	ndler			. '	Onham		
212' hould be nd Mental is marke itic event		19a. Informant's Name/Relationship		117	- ,			ber, City or Town, Stat			
e, MD  I and 2 sho Health and item 27 is		Kathryn M. Char 20a. Method of Disposition	ndler Moth		1222 E. Be		Avenue, Ba	altimore, M			
		1 X Burial 2 Cremation	Removal from State	crema	tory or other place)  Carmel Cem		9-25-06	Dundalk,	·		
Baltimore permit Pages   Department of Important: If injury or other	-	4 Donation 5 Other Special Signature of Juneral Service Lice									
Ba perm Depa Impo	I	Brown Main	0.1300		22, Name and Add	North A	Ave., Balt	imore, Md.	21202		
Physician	6 5	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and									
/Medical Examiner		Immediate Cause (Final disease a Dilated cardiomyopathy									
A		or condition resulting in death)  Due to (or as a consequence of):  b.									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):								
	Examiner	Unsease of injury that initiated events resulting in death) Last Due to (or as a consequence of):									
ecuted and transit			d								
'60, ate be exe ohysician a	Medical	X UNPENDED			, perME,g860,	10/11/06	TT	23d. Date of deliver			
876 tificat ing phy as the	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c, If yes, outcome 1 Live birth		2 Fetal death	3 Ectopic p	pregnancy	Month	ry Day <b>Y</b> ear		
Box 687  • death certific, the attending p	sician	1 Yes 2 No 9 Unkno	4 Pregnant at tir	me of death	5 Other (Specify)						
D. B. It the de by the ached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the ca									
, P.O. ires that the signed by	d by	1 Yes 2 No 3 Probably 4 VUr									
ords, w requir	Completed						24a. Was a		utopsy findings available completion of cause of		
Recc The lav	mo m						perfor				
tal Rec ician: The certificate rector, page	BeC	25 Was case referred to medical examiner?	Check only one)								
Division of Vital Records, tal or attending Physician: The law requirers after cleath all Director: After this certificate has been sited in by the funeral director, page 2 should the control of the co	2	1 Ves 2 No Indeptient 2 ER/Outpatient 3 DOA Sure 4 Nursing Home 5 Residence 6 Other									
ion of tending Pheath tor: After the funeral	ion:	1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Yea	ir)		Yes 2	I	iow injury document			
ivision or Atten after death Director:	ficat	2 Accident Investig 3 Suicide 6 Could n	290 Place of Injur	ry - At home, t	farm, street, factory, of	fice building, etc.			ural Route Number, City		
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)  Suicide 6 Could not be determined (Specify)									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		Check only	ician: To the best of my length								
To the vithing To the company	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
		701-11	28 K	Ì	C	O.C.M.E.		September 19,			
<b>—</b>		30 Name and address of person wh	no completed cause of dea	ath (Item 23a)					<del></del>		
φ			sistant Medical Exa		11 Penn Street,	Baltimore, M	D 21201				
Si Regis	tate	31. Date filed (Month, Day, Year) SEP 2 2	2006 32. Redistrar's		Louise						
Negis	CIECLE 1	10 10	7-3-00								

Floyd Cook

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0725 hrs September 18, 2006 Medical Examiner FLOYD COOK 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital STU Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs last birthday) **Funeral** Foreign Country) MD. Hours Months Days Director 214 50 2940 56 JULY 6,1950 1 XM 2 Usual Residence of Deceden 10b. County Oc. City, Town or Location 10d Inside City Limits any BALTIMORE COD AVENUE 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. 1009 HOMEWOOD MD. N/A permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1009 HOMEWOOD AVE 21202 USA. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes If Yes, Give Year 3 Widowed 4 Vivorced 1 Yes 2X No specify Specif BLACK à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 9TH JANITOR NURSING HOME 1B Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLOYD COOK SR. LILLIAN BETHEL 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S SIMINIECE COOK /DAUGHTER 1828 PRESSTMAN ST. BALTO, MD. 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State TRINITY CEMETERY APR. 26, 2006 BALTO, MD. Other Specify Donation 5 21 Signature of Funeral Servi Address of Facility N B . SCRUGGS FUNERAL HOME Part I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1213 Approximate Interval Physician /Medical Between Onset and Death a. Gunshot wound to head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit hvsician/Medical UNPENDED AMENDED attending physician or use as the burial item#10c,20b,perFH,G859,9/22/06 TT Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. ᇟ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: 1 V Yes 27. Manner of Death 28a. Date of Injury 2Bb. Time of Injury 2Bc. Injury at Work? 2Bd. Describe how injury occurred Medical Certification: Sep 11, 2006 Subject shot 1442 hrs Natural 1 Yes 2 ✔ No 5 Pending 2 Accident Investigation 2Be. Place of Injury - At home, farm, street, factory, office building, etc 2Bf. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State determined (Specify) Rowhouse 1828 Presstman Street, Baltimore, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. September 19, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day, Y State 2006 Registrar

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State of Maryland /		t of Health and e <i>of Death</i>	Mental Hygie		30108	
			Decedent's Name (First, Middle, Last)	)		J 0, D 00	2. Date of Death	NO.	3. Time of Death	
	Physici /Medic	al	ANN HEA		CLAR	KE Town, or Location of Dea	Sept. 1	Day Year  County of Death	8:12 Am	
	Examin Funeral Director	er	UNION MEMOR 5. Social Security Number 6. Se	RIAL HOSPITA	L	BALTIM	ORE.	A)		
	D D		Usual Residence of Decedent  10a, State  10b, County	10c. City, To	wn or Location		JEPT 14,1	1	Od. Inside City Limits	
	the Mar 28a-f et	Director	MARYLAND  10e. Street and Number	IA	10f. Zip	BALTIMO Code	RE CITY	Citizen of What Coun	1 XYes 2 □ No	
	eath with	erai Di	3610 FAIRVI	EW AVENUE  12. Was Decedent Ever in U.S.	<u> </u>	212	16	USA	٠.	
920	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow (a Medical Exacilier cast Le rictified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, spec	lent of Hispanic Origin? ( lify Cuban, Mexican, Pue	Specify Yes of No- irto Rican, etc.)	14. Race - Americ Black, White,		
215-0036	hin 72 ho a. an "natur Medical	Completed	15. Decedent's Edu (Specify only highest grad		a. Decedent's Usua (Give kind of work life. DO NOT us	k done during most of w	orking 16I	o. Kind of Business/Inc		
2	al Hygiend al Hygiend d'other the	Ве Соп	17. Father's Name (First, Middle, Last)		AILORK	SEAMSTRI 18. Mother's No	ESS Came (First, Middle, Mar	ELF-E/	nployed	
Maryland	should to and Ment marked umatic	卢	19a. Informant's Name/Relationship (Ty	pe, Print) 19	b. Mailing Address	(Street and Number or F	NA H Rural Route Number, C	ity or Town, State, Zip	TER Code)	
Baltimore, M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: I flem 27 is marked other then, 'natural; or theme 23a or 28a-f show eny injury or other treumatic event, it a Medical Examinar mast be notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)		of Disposition (Namery, crematory or ot	ther place)		C. Location - City or To		
Baltir	permit. F Depertme importar eny injur		21. Signature of Funeral Service Licens	N. William		ATORY 197- d Address Facility PH BRO N FULTOR	WN JR, FO	DALTIMO INERAL M ALTO, ML		
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the death. Do ne cause on each line.	not enter the mode	of dying, such as cardi	ac or respiratory arrest,	din l	Approximate Interval Between Onset and Death	
	/Medical Examiner	er	resulting in death)  Sequentially list conditions,	rebuty						
8760,77	cate be executed physicien and the burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
9	ertificate ling phys e as the	Medicai	IF FEMALE:	3c. If yes, outcome of pregnancy						
.O. Bo	The law requires that the death certific ate has been signed by the ettending page 2 should be detached for use as	ition; To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23d. Date of delivery  Month Day Year					
rds, P	w requires that the de been signed by the e should be detached f		Part II. Other significant conditions con		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑Unknown					
Division of Vital Records, P.O. Box	: The law recate has be page 2 sho		Diabetes				24a. Was an autopsy performed 1 Yes 2	24b. Were autop prior to com death? No 1 \(\sum \text{Yes}\)	osy findings available apletion of cause of	
<u> </u>	ticien: Th certificate rector, pag		25. Was case referred to medical examiner?	lospital:	=======================================	26. Place of De	ath Check only one			
ō	Phys this ral dir		1 ☐ Yes 2 ☑ No ☐ 27. Manner of Death	1 □ Inpatient 2 □ EH/O		A Vursing	Home 5 Residence		)	
5	nding Physicien: th. : After this certifica s funeral director, p		1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	28d. Describe how injury occurred					
Divisi	to the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Physical Certifier 2 Medical Examination	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	ge, death occurred a nd/or investigation,	it the time, date and place in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)	
)	To t To t	×	29b. Signature and title of certifier	UMD		License number		Date signed (Month, D		
	6		30. Name and address of person who co		(Type, Print) \$2, N	ZITAN ST	Fa. 6 30 d	BALTIM	NDF MID	
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature	0 2 1 (V	07/1/10 3/	SAN OF 200	- MCCON	V/- L 111/2/0	
	Registra		CED at a sono	A December 1	Tales.					

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Donald Caldwell 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1442 hrs **Medical Examiner** Dona1d Caldwell September 18, 2006 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University Hospital-Shock Trauma If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or 5. Social Security Number 6. Sex 7 Age (In vrs. last birthday) **Funeral** Country)MD 214-64-8469 50 Months Days Hours Nov. 26, 1955 Director XM 2 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County VA Norfolk Norfolk Yes 2 No 28a-f show s 23a or 28a-f show e notified at once. hours after death with the Maryland Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country 140 W.Leicester Avenue 23503 USA Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No- Race - American Indian, Black. 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married X Yes Black f Yes, Give Year 1 Yes 2 X No specify Specify Widowed Divorce ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Naval Air Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", the Medical F Cargo Plane Loader Technician Baltimore, MD 21215-0036 ages 1 and 2 should be filed within nt of Health and Mental Hygiene ut: If item 27 is marked other than other traumatic event, the Medica 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Crawford R. Caldwell Be Elizabeth Roberts 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrice Caldwell/Wife 140 W. Leicester Ave. Norfolk, VA 23503 20b. Place of Disposition (Name of cemetery, <del>UNV</del>, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Albert G. Horton Veterans Norfolk, VA 9/27/2006 mportant: Memorial Cemetery Donation 5 Other Specify 21. Signature N Funeral Service Licensee Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore MD 212 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a Part I Enter the disease or Physician failure. List only one c Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or hijus) that it itiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X AMENDED attending physician UNPENDED item#20b,perFh,G859,9/28/06 TT Box 68760. IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes this certificate ✓ Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 / Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27 Manner of Death Sep 18, 2006 Certification Driver auto fixed object collision 1 Natural 1335 hrs 1 Yes 2 V No To the Funeral Director: completely filled in by the f 5 Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide (Specify) Interstate/Express I-295 south of pedestrian walkway, Baltimore, M Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E September 19, 2006 30 Name and address of person who completed cause of death (Item 23a)

State Registrar

Zabiullah Ali, M.D.

Day 2

2006

Assistant Medical Examiner

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:25 AM Eleanor Duviella 2006 se otembre /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 17/1925 Birthplace (State or Foreign Country)
Cuba 5. Social Security Number **Funeral** 1□M 20 F 090-24-5954 Director Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore City Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2403 E. Federal Street 21213 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or Itema 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health Care al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LPN 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Sumame) Ferno Holly

19a. Informant's Name/Relationship (Type, Print) Charles Duviella/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 E. Federal Street Baltimore, MD 21213

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

Sep 24 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory Inc. 2006

Beltsville, Maryland

20c. Location - City or Town, State

Rith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

22 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-

Immediate Cause (Final disease or condition resulting in death) Vementia Due to (or as a consequence of): CONONCY An-Anter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between

Onset and Death

year.

Due to (or as a consequence of) entension

years

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

9 Unknown

4 \ Homicide

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

9□ Unknown

3 DEctopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

24a. Was an

autopsy performed Yes 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 🗌 Suicide 6 ☐ Could not be

28c. Injury at Work?

1 Tes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

September

State Registrar

1%

31. Date filed (Month, Day, Year)

Michael

Memorial 32 Registrar's Signature

Union

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

physicien

attending for use as

ete has been signed page 2 should be de

this : After this funeral o

Director:

within 24 hours a
To the Funeral C

death.

Physician/Medical

δ

Completed

Certification: To

Medicai

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.

O. Box 68760,

**ORIGINAL** 

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of I rtificate of	lealth and <i>Death</i>		giene2006	30111
	- · · ·		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day Year	3. Time of Death
	Physicia /Medic	_	RONALD DANTLE	= 4		*		SEPTEMBE		. 1 / 7 / 11
	Examin		4a. Facility Name (If not institution, give s				or Location of Dea	ith	4c. County of De	ath
				VD MEDICAL SY		BALT7/	If Under 24 Hr	S 0 B-1- + 1 B-1		dhalaa (Caa e
	Funeral Director		5. Social Security Number 6. Sex 1型	M 2□F 5	. last birthday)  Yrs.	Months Days		. (Month, Da)	v, Year)	rthplace (State or Foreign country)
		}	Usual Residence of Decedent					07/29	/1954	DC
	ylanc how		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	88-f	cto	MD Montgome	ry Si	lver Sp	ring				1 ☐ Yes 2 🔯 No
	ਜ਼ੈਸ 2 2 2 2 2 2 2 2 2 3 3 3 3 3 3 3 3 3 3 3	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	s 23s	sral	512 Pickwick Villa	<u> </u>	10 12 1		901	Charity Van as Na	USA	orican Indian
_	ter de	by Funeral Director	11. Marital Status 1 Never Married 2 Married	<ol> <li>Was Decedent Ever in I Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>	0.5.	f Yes, specify Cub	oan, Mexican, Pue	Specify Yes or No- into Rican, etc.)	Black, Wh	
20	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specity:		Specify: B	lack
Ş	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occu kind of work done	pation	orkina	16b. Kind of Busines	s/Industry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)			_
2	be filed within 72 hours after death with the Maryland Hygiene.  do ther than "natural" or items 23a or 28s-f show do other than "natural" or items 23a or 28s-f show event, I'm Medical Evanimar must be notified at		12		Civil	Penalty			Department	of Labor
DUE BU	e d la b	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,		
Ž	12 should be filed wo and Mental Hygie the marked other the raumatic event, ID.	ပ္	Calvin Adams  19a. Informant's Name/Relationship (Type	ne. Print)	19b. Mailir	ng Address (Street		Bural Boute Number	y or, City or Town, State,	Zip Code)
<u>¤</u>	l and 2 s lealth an im 27 is her trau		Ruth E. Dantley	,		-			ing, MD 20	
ē,		l	20a. Method of Disposition	206.		sition (Name of matory or other pla	the second second	Date	20c. Location - City of	
Ê	Pages nent of int: If its iny or o		12 Burial 2 ☐ Cremation 3 ☐ Real 4 ☐ Donation 5 ☐ Other (Specify)	amovai irom State		National	1	<b>'-</b> 06	Laurel, M	D
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service License						Funeral H	
<b>m</b>	88 = 88	13	J. P. Ikar	skall			42	17 9th S	t NW, Wash	, DC 20011
ı			23a. Party. Enter the disease, or complication shock, or heart failure. List only on	cations that caused the dea e cause on each line.	ath. Do not ent	er the mode of dy	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
y	Physician		Immediate Cause (Final disease or condition	ACUTE MY	/ELOID	LEVKEN	1/A			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
H		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quanca of):					
	uted Insit	Examiner	Cause (Disease or injury	·	4					
Ć.	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exa	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):					
8760	iysicia	dical								
Ó	ng ph as th	Ved	IF FEMALE:							
Box	death certificated at the second of the seco	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	tal death 3	Ectopic pregnanc	:у		23d. Date of d Month	elivery Day Year
	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify) _				,
0.	that the de ned by the a detached t		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
g Q	uires signa Id be	d by		_		, , ,		101	′es 2. \$\frac{1}{2} \text{No 3   1}	robably 4 Unknown
Ö	w requir been si should	lete						24a. Was	an 24b. Were	autopsy findings available
Re	The lav te has age 2	Completed							rmed? prior to	completion of cause of
Division of Vital Records,		0	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only o		s 2 No
<u>&gt;</u>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	] ER/Outpatier	nt 3 DOA	hon		lence 6 Other (Sp	ecify)
0	Attending Physician: r death. ector: After this certifice by the funeral director. p		27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at ork?	28d. Describe h	ow injury occurred	
Sio	uttendin death. ctor: Aft y the fur	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No			
$\leq$	f or Attenater deat after deat Director:	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		City or Tow	Street and Number or I m, State)	Ru <i>ral R</i> oule Number,
_	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After thcompletely filled in by the funeral	S C	29a, Certifier 1 € Certifying Phys	ician: To the best of my kr	nowledge, deat	n occurred at the fi	me, date and place	ce, and due to the	cause(s) and manner	as stated.
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Examir	er: On the basis of examinand manner stated.	nation and/or in	vestigation, in my	opinion, death oc	curred at the time,	date and place, and do	ue to the cause(s)
	within 24 To the Fi	Me	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)
			14- W	ZMD		PIF	7740		SEPTEMBER	20,2006
	7		30. Name and address of person who co							
0	3 Sta			mpleted cause of death (lite 2 SOUTH GR 33 Registrar's Sign	EENE	STREET,	BALTIM	ore, MD	21201	

State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year September 20,2006 **Physician** 4:45 P.™ Samuel Anthony Dalfonzo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 □ F Yrs 216-14-7306 85 April 4, 1921 Maryland Director Usuat Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or frams 23a or 28a-f ahow the Madical Examinar must be notified at 1 ☐ Yes 2 TNo Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane Apt CC512 21228 USA Pages 1 and 2 should be filed within 72 hours after death a neat of Health and Mental Hygiene.
ant: if item 27 is marked other than "neturel; or items 23, and other treumetic avent, it a Madical Examination must Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1945 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Accountant State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Dalfonzo Grace Katie Liberto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pers.Rep Samuel J. Dalfonzo 104 Wyndcrest Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department important: if any injury or once. New Cathedral Cem. 9/26/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fundal Service Licensee 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final astri' Physician 2 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any the important cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 20 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were aulopsy findings available prior to completion of cause of death? performed? certificate 1 Tyes 2 No 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 🔎 No Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Quatural 5 Pending s after dec. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number ( D why completed cause of death (Item 23a) (Type, Print) 30. Name and a drass of p (any (ca21.5 Choice RK Marden 711 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 2 2006 Registrar

John Eyring

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 30113 Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day September 19, 2006 Year Medical Examiner JOHN F. EYRING. JR. 1110 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City, Town, or Location of Death 3900 North Charles Street Apartment 14 **Baltimore City** N/A 5. Social Security Number Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. B Date of Birth (MM/DD/YYYY) 9 Birthplace (State o **Funeral** Country MARYLAND Director Months Davs Min Hours 74 216-28-4086 11-10-1931 XX M 2 F Usual Residence of Decedent any 10a State 10b. County Oc. City, Town or Location 10d Inside City Limits MD. or 28a-f show N/A BALTIMORE CITY 1XX Yes 2 No s 23a or 28a-f show e notified at once. . Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: I friem 27 is marked other than "natural", or items 25a or 28a-f she or other transmarie event, the Medical Examiner must be upfiled at once Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 1407 21218 3900 U. S. A. NORTH CHARLES STREET, APT Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2XX Married Yes WHITE ff Yes, Give Year Divorced 1 Yes XX No specify Specify à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) HEALTH CARE Baltimore, MD 21215-0036 MEDICAL DOCTOR **PLUS** 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) EYRING, JOHN F. SR. VERONICA LOCHBOREDLER Be 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY EYRING С. (WIFE) CROSS KEYS ROAD, BALTIMORE, MARYLAND, 21210 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State 9-23-2006 TIMONIUM, MARYLAND DULANEY VALLEY M.G. 4 Donation 5 Other Specify permit. Departm 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1050 YORK (R.G.RUTH) R. A. RUCK TOWSON FUNERAL HOME. INC. TOWSON, MD. 21204 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED attending physician or use as the burial AMENDED item#1.23a.27.perME.g860. 10/5/06 TT To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Dav Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital. 1 Other<sub>4</sub> DOA ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other. Scene Inpatient 2 1 🗸 Yes ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. September 20, 2006 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Morth, Pay Year) 32 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene2006For Stete Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 19, 2006 SEPT. **Physician** FRANKLIN JOSEPH EMMONS РМ 7:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BRYANT WOODS ASSISTED LIVING HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 NEW YORK 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F Director 098-22-0810 MAR. 24, 1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic event, the Midical Examiner must be notified at 1 ☐ Yes 2 📆 No MD. HOWARD Director COLUMBIA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10461 WATER FOWL TERRACE 21044 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL EDUCATION TEACHER EDUCATION 8 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LAURA O'BRIEN RALPH EMMONS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 833 S. ELLWOOD AVE., BALTIMORE, MARYLAND HEIDI DERRICKS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State ö Department of important: If eny injury or once. METRO CREMATORY 9/21/2006 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a/Part1 nmediate Cause (Final heimers **Physician** disease or condition resulting in death) /Medical Due to (or as **Examiner** d. val CON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) **burial-transit** The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a Was an 1 ☐ Yes 2 No Hospital or Attending Physician: After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Med. 31. Date filed (Month, Day) Year) 32. Registrar's Signature State Registrar SEP 2. 2. 2006

			1 - For State Registrar	State of Maryland	d / Depari <i>Certi</i>	tment of H	lealth and I Death	Mental Hy	giene	2006	30115		
		- 3	Decedent's Name (First, Middle, Last)			2. Date of De	ath		3. Time of Death				
	Physici		Benjamin FA	ank Feast	er			Month	Day 18	2006	6:30 PM		
	/Medic Examin		4a. Facility Name (If not institution, give s			b. City, Town, or	Location of Deatl	*		ounty of Death	1		
		366	Fairland Nursing ar	nd Rehabilitation	Center	Silver	SPRING	`	Me	intgom	PRV		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. is	ast birthday)	if Under 1 Year	If Under 24 Hrs.		th Year		lace (State or Foreign try)		
	Director		249-52-2989	M 2□F 72	Yrs.	Months Days	Hours Min.	06/c2/	06/c2/1934 Country) SC				
	P.		Usual Residence of Decedent				<u> </u>						
	urylar show		10a. State 10b. County		, Town or Local	tion				11	Od. Inside City Limits		
	Ba-1.s	cto	MD Prince G	eorge's Col	lege t	ark			-		1 □ Yes 2 X No		
	ith the Marylar or 28a-1 show	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Coun	try?		
	23a		9604 51 St Pla	ce		20740	)		USA	t			
	ep .	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Wa	is Decedent of H	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No o Rican, etc.)	14.	Race - Americ Black, White,			
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🗷 No If Yes, Give	1	Yes 22 No	Specify:		Su	pecify:			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta Madical Ezandiar must be notified at	d b	3 ☑ Widowed 4 □ Divorced	Year or Dates:						Blace			
쟌	na 72	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give kir	nt's Usual Occup nd of work done o NOT use retired	during most of wor	king	16b. Kind	of Business/Inc	lustry		
12	within	E D	Elementary/Secondary (0-12)	College (1-4or 5+)	Steel >		"/		Raible	ehem á	Slack		
	Hygid Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg Hyg		17. Father's Name (First, Middle, Last)	NIA	STEEL	NOT THE	18. Mother's Nar	ne (First, Middle	1 400		STEEL		
an	od o	Be	110 1 -	0.0			Nonie	•		mamo)			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hyglene Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, the Middical Express rount by natified at	P P	19a. Informant's Name/Relationship (Ty)		19h Mailing		and Number or Ru		/	own State Zin	Codal		
Ma	d 2 s th an trau		D 1 0 1	Laughter)		-1.6		_	-				
	1 and Health tem 27 other tr	18	20a. Method of Disposition		ace of Dispositi	ion (Name of tory or other place	ce. Celle	Date Pur	20c. Local	ion - City or To	wn. State		
Baltimore,	permit. Pages 1 au Department of Hea Important: if Item any injury or othe once.		1 🗷 Burial 2 ☐ Cremation 3 ☐ R					1					
≣	permit. Pages Department of Important: If It any injury or c		4 Donation 5 Other (Specify)		y Memor	rial larl	K 9/22	3/2006	Mana	allstou	on MD		
Ba	permit. Departr Imports any inju		21. Signature of Funeral Service License	0	Vai		ssot Facility	Funera	, SVC		1220		
360	34		raugno C	. Greene	515					MDS			
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each line.	. Do not enter	tne mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death		
A	Physician		Immediate Cause (Final disease or condition resulting in death)	Demen	tia						1 year		
	/Medical Examiner		vocating in docum	Due to (or as a consequ	ence of):						•		
		_	Sequentially list conditions, b		anno of).								
	₹ W &	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ierice or):								
	and I-trar	хап	that initiated events cresulting in death) Last	Due to (or as a consequ	lence of):								
8760,	sician and	a E											
87	the the	dical	<b>—</b> d										
9 ×	eath certific attending p for use as	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnar	nev								
Вох	atten for u	ian	in the past 12 months?	1 Live birth 2 Fetal	death 3□Ed	ctopic pregnancy	N/A		230	<ul> <li>Date of delive</li> <li>Month</li> </ul>	ry Day Year		
Ö	t the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	iatii 5 🗆 O	ther (specify)	0 10						
P.0	that the		Part II. Other significant conditions con	tributing to death but not resu	Iting in the unde	erlying cause give	en in Part I.	23e. Did 1	obacco use	contribute to th	e cause of death?		
ds,	sign d be	Completed by	T . 1. 1	ident Diab		, , ,			Yes 2□N		ably 4 Munknown		
Ö	v requir	ete	11										
3ec	has has	jdπ	Fly pertension					24a. Was		4b. Were autop prior to con death?	osy findings available apletion of cause of		
a F				ease				1 ☐ Yes	2 1 No	1 Yes	219 No		
VIII.	ysician: Is certific director,	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Dea						
of Vital Records,	문 두 등	2	1 Yes 2 No	1   Inpatient 2   E		3□ DOA	er: 4 Nursing H				)		
Ľ.	ding I h. After funer	ion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe	now injury o	ccurred			
Sic	death death ctor: y the	icat	2 Accident investigation 3 Suicide 6 Could not be	20a Blood of Injury At ha			Yes 2 □No	OOF Leasting /	Ctooolood				
Division	or Attendate after death	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, rarm, street )	t, factory, office		City or To	wn, State)	umber or Hural	Route Number,		
_	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer		29a. Certifier 1 Certifying Phys	ician: To the best of my know	vladge death -	accurred at the time	data and alase		(-)				
	Hos 24 hc Fun stely	Medical	(Check only 2 Medical Examination)	er: On the basis of examinati and manner stated.	ion and/or inves	stigation, in my o	pinion, death occu	rred at the time,	date and pla	d manner as sta ace, and due to	ated. the cause(s)		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	and marrier states.		29c. Licenso	e number	T	29d. Date s	igned (Month, E	Day, Year)		
	⊢ ≯ ⊢ 8		DO Y										
	1		30. Name and address of person who co	mpleted cause of death (!!	22a) /T Pri	コレショ	8656	(	repte:	mber =	33,2006		
	1			8609 Second	Loa) (Type, Pri	HOUD (	Silvers	0050c A	- 1L	10010	12, 200 k		
70	Sta	to	31. Date filed (Month, Day, Year)	Registrar's Signar	ure The	S (CITUIL)	DITAGE O	henry !	100	10710			
-4	Registr		SEP 2 2 2006	2. Registrar's Signar	Je Je								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fb 9860 10-5-06 yt
State of Maryland Department of Health and Mental Hygiene 2006

1- For Amend #17 Per FH G859 9/22/06 Ch
Registrar

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month BENJAMIN **Physician** -ORSYTHE Sestember 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner SE COURS BALTIMORE 130 N HOSPITAL 6. Sex M 2□ F If Under 1 Year | If Under 24 Hrs. last birthday) Date of Birth Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 48-240 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at 1 tes 2 □ No Director MD altinore 10e. Street and Number 300 Floor 10f. Zip Code 10g. Citizen of What Country? 2121 Avenue 15A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturel", or iten eny injury or other treumatic event, ILE MEJICAL EXAMPLE. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Epples Community Elementary/Secondary (0-12) College (1-4or 5+) Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barthony Forsythe (00 Des 19a. Informant's Name/Relationship (Type Print) Mc Connell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 21123 5 Bannock Ct., & Randalstown, MD
20c. Location - City or Town, State SON IGMIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State textus Cometer 21. Signature of Funeral Service Licensee Services et. Ballomo 21224 Balto. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician EUMO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 100 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

physician and the burial-transit Division of Vital Records, P.O. Box 68760 attending physic cete has been signed by page 2 should be detach certificete has To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifice

28a-f ehow

or iteme 23s or

Maryland 21215-0036

Saltimore.

State Registrar

Medical

29a. Certifier (Check only one)

OSITA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Opro

30. Name and address of person who completed



ath (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10030355

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND 11 H.M. 14, per FH, G559, 222 06, WS

State of Maryland / Department of Health and Mental Hygiene 2006

	7.	Registrar	· (F) · 18 · 14 · 1			Cei	tificate	e of L	Death	1	F	leg. No.		301
hysician /Medical		Decedent's Nam Joseph	ne (First, Middle, L Glazer	ast)							2. Date of Dea Septemb		9, <del>20</del> 0	3. Time of Death 2:30 PM
Examiner	4a	Facility Name (	ILnot institution, g Lard Ave	ive street and number. #336	er)		4b. City,		Location of Chevy		se		unty of Deal	
neral ector		Social Security N .23-12-3		Sex 7. MCXM 2□F	Age (la yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth		9. Birt NY Co	hplace (State or Fore
		ual Residence o a. State	f Decedent 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Lim
tor tor	M	D	Montgo	mery		vy Cha								1 □ Yes 2 <del>/</del> □
3a or 28a al be not	10	e. Street and Nu. 701 Wil	mber lard Ave	nue #336			10f. Zip 208	Code 815-				10g. Citizer USA	n of What Co	ountry?
Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 ahow any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11	. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 🌠 Married 4 □ Divorced	12. Was Decede Armed Force 1 Yes 24 If Yes, Give Year or Date	is? No		Vas Deced Yes, spec			gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
re Medical	-	(Spec Elementary/Seco	15. Decedent's locify only highest gondary (0-12)	Education rade completed) College (1-4	5 <sup>5+)</sup>	16a. Deced (Give life. L Educa	kind of wor OO NOT us	k done d e retired,	uring most		ng	16b. Kind Gove:	of Business/	Industry
atic event, To Be C	17		(First, Middle, Las Glazer	, Last)				18. N Ti			(First, Middle, Horowitz		ımame)	
er trauma		a Informant's N Mildred	ame/Relationship K. Glazer	(Type Print) :/Wife		19b. Mailin <b>4701</b>	g Address Will:	(Street a ard	<sup>nd Numbe</sup> <b>Ave</b> nu	r or Rura e #3	Route Number 36 Chev	r, City or To Y Cha	own, State, 2 ase, MI	Zip Code) D 208 <b>1</b> 5-
ury or othe	20		:	□Removal from Sta	ra	ace of Dispo- metery, cren esapeal	atoni ar at	that mina	ory q				tion - City or Ville,	Town, State Maryland
any Inji	21	. Signature of Fu	uneral Service Lice	ensee	molas	8 38	а <b>рр</b> • <b>г</b> ч 33 Gi:	AMERS et Av	spf Fecilio	rema	tion Ser r Spring	vices , Mar	yland	20910
physicien and lead in the buriat-transit and lead in the buriat-transit and lead in the buriat-transit and lead in the buriat-transit and lead in the buriation in the buriation and lead in the buriati	di	imediate Cause sease or condition sulting in death) equentially list coany, leading to interest under the season of at initiated events sulting in death)	onditions, nmediate ertying injury s	b. Due to (or	as a consequal as a c	ence of):								Onset and Death 3 months
detached for use as the alternating pay detached for use as the alternation of the altern		FEMALE: b. Was deceden in the past 12 1 Yes 2[ 9 Unknown	months? □No		2 Fetal at time of de	death 3	Ectopic pre Other (spe					23d	I. Date of deli Month	ivery Day Year
be d	Pa	rt II. Other signit	ficant conditions	contributing to death	n but not resul	lting in the un	derlying ca	iuse give	n in Part I.					the cause of death?
page 2											24a. Was a autops perform	y	death?	topsy findings availa completion of cause of
Be Be	25	. Was case refer examiner?		Hospital:				Othe	er.		(Check only on			
the funer	27	Manner of Deat    Manner of Deat   Matural   Accident   Suicide		28a. Date of II	njury Day Year)	ER/Outpatient 28b. Time of Injury	M 28	Bc. Injury Work 1 🗆 Y	4   1401	10	ne 5 Reside 8d. Describe ho	ow injury od	ccurred	
completely filled in by the		4 Homicide	determine	d 288. Place of building,	etc. (Specify)	)					City or Town	n. State)		rai Route Number,
completely filled		(Check only one)	2 Medical Exe	hysicien: To the be miner: On the basis and manner	of examination	viedge, death on and/or inv	estigation,	in my op	inion, deat	place, a	d at the time, d	ate and pla	ace, and due	to the cause(s)
000	29	b. Signature and	title of certifier	Ster	P			License				9d. Date si /20/0	igned (Mo <i>nti</i> : 16	n, Day, Year)
( ( )				completed cause o 221 Mercar				·	077/					W

DHMH 17 Rev 1/2001

Registrar

SEP 2 2 2006

			For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	rtment of F	lealth and N Death	Mental Hy	giene 2	006	30118
	Physicia	an	1. Decedent's Name (First, Middle, L						2. Date of De	Day	Year 200 L	3. Time of Death
	/Medic Examin	al	Edith Marde		ber)		4th City, Town, o	r Location of Death	Septemb		unity of Death	sd
	Funeral Director		5. Social Security Number 6. 212-20-6081		. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. July 2	rth ay, Year) 20, 192	9. Birthe Cour Mary	place (State or Foreign ntry) Land
	-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Harford	3		y, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2 No
	a or 28a Le roll	Dire	10e. Street and Number 4017 Webster Ro		11000	20 00	10f. Zip Code 21078	0		10g. Citizen USA	of What Cour	ntry?
9	tiled within 7.2 hours after beam with the maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, I've Medicul Exarchive must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give	es?			dispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	0- 14. [	Race - Americ Black, White,	etc.
21215-0036	n /2 nours a "natural", o	Completed by	3 📑 Vidowed 4 🗆 Divorced  15. Decedent's (Specify only highest g	Year or Date Education rade completed)	les: 	16a. Deced	ent's Usual Occup	pation during most of wor	king		W of Business/In	hite dustry
212	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, I a.M.		Elementary/Secondary (0-12) 11	College (1-	4or 5+)	Compu	ter Opera	ator 18. Mother's Nan	o /First Middle		Govern	ment
Maryland	uid be m fental H rked otl tic ever	To Be	17. Father's Name (First, Middle, Las Charles Alexand		1			Edith	(nmn)	Irwin	патеј	
Mary	a z snould be h and Mental 7 is marked o traumatic ev		19a. Informant's Name/Relationship			0.000	PERMIT	and Number or Ru		-734		
Baltimore, I	permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trai		Myra G. Hartwig  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3  4 □ Donation 5 🖾 Other (Spec	☐Removal from S	tate 20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date	20c. Locati	on - City or To	and 21078 own, State cryland
Baltii	permit, I Departmi importar any injui		21. Signature of Funeral Service Lic	ansee.	)	<u>M</u>	Name and Addre COMAS FU	uneral Ho	me, P.A	vadon .		nd 21009
	hysician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_a	used the deat	10 043	er the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
)°092	ate be executed thysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec or as a consec							
O. Box 68760,	eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Feta int at time of c	al death 3	Ectopic pregnanc Other (specify)	у		23d.	Date of delive	ery Day Year
M ds, P.	w requires that the dispersion is been signed by the should be detached	by	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the u	nderlying cause giv	ven in Part I.		tobacco use o		he cause of death?
Arth Record	hysician: The law rec his certificate has bee I director, page 2 shot	Completed							24a. Wa auto peri 1 🗆 Yes	s an 2-	4b. Were auto prior to co death? 1  Yes	opsy findings available impletion of cause of
	ician: certifica rector, I	Be	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of Dea				
JO LY ion of	ng Pl	ation; To	1 Yes 2 Too  27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date o		ER/Outpatier 28b. Time of Injury	28c. Inju	4 X Yursing F	ome 5 Res 28d. Describe			fy)
STLA	To the Hospital or Attending Phymylin 24 hours after death. To the Funeral Director: Aller th completely filled in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place buildin	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, str	eet, factory, office			(Street and No own, State)	umber or Rura	al Route Number,
	he Hospit in 24 hour he Funera pietely fille	edical	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physician: To the aminer: On the ba and mann	sis of examina	owledge, deatl ation and/or in	vestigation, in my	opinion, death occu	, and due to the irred at the time	, date and pla	ice, and due t	o the cause(s)
		M	29b. Signature and title of contifier	n A1.	andle	1 de	29c. Licens	2800		29d. Date si	gnéd (Monty,	6.
	E	ata.	30. Name and address of person what was a state of the st		o of death (Ite ON OO egistrar's Sign	ALD)	319 S	outh Unio	on Ave.	, Havre	e de Gi	21078 race, MD
	Regist	ate rar	SEP 2 2 2	. 2	district of	1 for						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	arylan		artmen tificate			nd Mei			06	3011	9
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Li     Richard     4a. Facility Name (If not institution, gir	,		G	10 V N 4b. City,		Location of I	Se	Date of Dea Month Ptember	Day	Year 2006 of Death	3. Time of Death 14: 20	
5	Funeral Director		5. Social Security Number 6. 213-14-4325	HOPKINS Sex 7. Ag		taL last birthday) Yrs.	Ba If Under Months	1 Year Days	If Under 24	Hrs. 8.	Date of Birth (Month, Day ay 19,	1923	9. Births Cow Mary	A place (State or Foreigntry) Vand	gn
	e Maryland 3a-f ehow dilied at	ctor	Usual Residence of Decedent  10a. State  Md.  Baltimo	ore	1	, Town or Lo							1	0d. Inside City Limit	
	th with th	Funeral Director	10e. Street and Number 623 Budleigh	Circle			10f. Zip		21093		1	og. Citizen of V		itry?	
9036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or iteme 23a or 28a-1 ehow event, the Madiral Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes 2			n? (Specify Puerto Ric	y Yes or No- an, etc.)		ce - Americ ck, White,	etc.	
Maryland 21215-0036	filed within 72 h Hygiene. other then "netuent, in Madien	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)			life.	dent's Usua kind of wor DO NOT us ager	k done du	ırina most o	of working		16b. Kind of B	usiness/In	ustry	
yland	should be filed nd Mental Hygid marked other umatic event, I	To Be (	17. Father's Name (First, Middle, Las John Michael	Gorney					Eliz	abeth	n Ann	Maiden Suman Mikul	a		
	is 1 and 2 should of Health and Meritem 27 is market other traumatic		19a. Informant's Name/Relationship Mrs. Rose Marie 6 20a. Method of Disposition				Budle	eigh			nonium,	, City or Town, Md. 2	1093		
Baltimore,	permit. Pages Depertment of h Important: if its any injury or of		1 Burial 2X Cremation 3 4 Donation 5 Other (Spec	(y)	CE	top Se	ervice	Co.	9-	-22-0		Tows	on, M		
Bal	Dermi Deperminent		21. Signature of Funeral Service Line 23a. Part1. Enter the disease, or con-		I the death			Tow Yor	son Fi k Rd.			Inc. 2120	4	Accrevimen	
ı	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Resp	irat	ery.	failu		, such as ca	irdiac or re	spiratory arr	est,		Approximate Interval Between Onset and Death 24 MYS	
3760,77	cate be executed physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last		ma() a consequ	ignar	114,11	ikely	y Cho	olane	giocar	cinom	a	6 minth	5
Records, P.O. Box 68760, &	at the death certifica by the attending pt tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre						te of delive	ery Day Year	
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant conditions Melanoma	contributing to death be	ut not resu	Ilting in the u	nderlying ca	use giver	n in Part I.		23e. Did tol	3.4		ne cause of death? ably 4 Unknow	'n
Division of Vital Records,	: The law re cate has be page 2 sho	Completed									24a. Was a autops perform	ned?	Were auto prior to coi death? 1 ☐ Yes	psy findings availab npletion of cause of 2  No	le
f Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 X inpatie	nt 2 🗆 E	ER/Outpatien	t 3□ DO	Other		1,111	heck only on	el ence 6 ⊡Oth	er (Specifi	v)	
sion of	fter ne	Certification: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	ry T	28b. Time of Injury		Bc. Injury		28d		ow injury occur		<u> </u>	
Divis	= = = =		3 Suicide 6 Could not l 4 Homicide determined	building, etc							City or Town	n, State)		l Route Number,	
	To the Hospital of within 24 hours af To the Funeral of completely filled in	Medical	29a. Certifier 1 Certifying P (Creck only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examinati	wledge, death ion and/or inv	occurred a restigation,	at the time in my opi	, date and p nion, death	place, and occurred a	due to the ca at the time, d	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)	
	To the within 2 To the comple	W	29b. Signature and title of certifier	A				License			2	9d. Date signe	d (Month,	Day, Year)	
•	4.5		Ibironke (					Res-	-000			Septemi	oer 1	6,2006	
	Sta Registř		30. Name and address of person who Ibironke Oduye 31. Date filed (Month, Day, Year)  SEP 2.2.2	bo The Jo	hns }	topkins	HOSPIT	ul.61	00 North	n Wolf	e street	Baltimo	re.Mu	ryland 212	181

Physicia	_	Registrar			Certifica	HE OIL	Jeani	1	Reg. No.	200	
	ın	1. Decedent's Name (First, Middle, Last)  COLYN H. HARRI	10.10.000.1					2. Date of Dea	ath Day	Yee	
/Medica	al .	4a. Facility Name (If not institution, give s	INGTON treet and number)		4b. Ci	tv. Town. or	Location of Deat	SE 2	20 4c.	2000 County of De	
Examine	3 i	Sinac hospital	of Balt	more			Baltimor	,			V/A
Funeral Director		5. Social Security Number 6. Sex 219. 32. 4674	7. Age (	In yrs. last birt	hday) If Und Month	der 1 Year s Days	If Under 24 Hrs Hours Min.		h y, Year) 1 <b>93</b> 5	9. B	lirthplace (State or Foreign Country) MA
ation beam with the Malyland or Items 23a or 28a-1 show indicer must be notified at	ctor	10a. State 10b. County  MD NA	-	BALTIM							10d. Inside City Limits 1 ■Yes 2 No
23a or 28	Funeral Director	10e. Street and Number 4001 BATEMAN AV	IENUE			Zip Code				zen of What	•
al', or Items	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	<ol> <li>Was Decedent Ev Armed Forces?</li> <li>1 ☐ Yes 2 M No If Yes, Give Year or Dates:</li> </ol>	er in U.S.		cedent of Hi pecify Cuba 2 <b>4</b> No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	1	Black, Wi	nerican Indian, hite, etc.
penint. Tages a fuel and Mental Hygene. Department of Health and Mental Hygene. Important: If Item 27 is marked other then "natural", or Items 23a or say injury or other traumatic event. It is Medical Examinating that Dage.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		Decedent's U (Give kind of life. DO NOT	work done o use retired,	turing most of wor	rking		nd of Busines	ss/Industry
ked other Ic svant.	To Be Co	12.14 GRADE  17. Father's Name (First, Middle, Last)  WILLARD L. CLAYIO	L YRS U		KIIGGI		18. Mother's Nar	me (First, Middle,	Maiden		<b>"</b>
h and M		19a. Informant's Name/Relationship (Type	_ ' / . '			ss (Street a	and Number or Ru	ıral Route Numbe	r, City or		
item 2	8	GARY C. HARRINGTI 20a. Method of Disposition		20b. Place of cemeter,	Disposition (A			RICHMON! Date	_		233 or Town, State
ment of tant: If it jury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		GREEN	moun		09.2				, MD
importing sny in		21. Sign ure of Fuperal Service License	Ĭ		VAUGHO	and Addres	S OF Facility	UNERAL S	SERV	ICE	
hysician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.	to my						4	Approximate Interval Between Onset and Death
/Medical Examiner			Due to (or as a o	4 4	dure						20 days
1 6 5	xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	R F	AILUR	E					20 days
attending physicien of for use as the burial	edical E	L <sub>d</sub> .		epsis	, , , , , , , , , , , , , , , , , , ,						20 days
within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physicie completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√ No 9 □ Unknown	ic. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	☐ Fetal death	3 □Ectopic 5 □ Other				2	3d. Date of d Month	elivery Day Year
s been signed be should be deta	<u> </u>	Part II. Other significant conditions cont	inbuting to death but	not resulting in	the underlying	g cause give	en in Part I.		baccous		to the cause of death?
ete hes beer page 2 shou	Completed							24a. Was a autop perfor 1 □ Yes	sy med?	24b. Were prior to death?	
certific ector,	Be	25. Was case referred to medical examiner?	ospital:			Otho		th (Check only or			
within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	tlon: To	1 Yes 2 No To Anner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Out 28b. Ti		28c. Injury Work	4 🗆 Nursing n	ome 5 Resid			recify)
s after dea	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, far (Specify)	m, street, fact			28f. Location (S City or Tow			Rural Route Number,
24 hours	edical (	29a. Certifier 1 V Certifying Physic (Check only one) 2 ☐ Medical Examination	ician: To the best of e er: On the basis of et and manner state	kamination and	death occurre Vor investigati	ed at the time on, in my op	e, date and place inion, death occu	, and due to the c rred at the time, c	ause(s) a date and	and manner a place, and di	as stated. ue to the cause(s)
within To the comp	Σ	29b. Signature and title of certifier  Rolcicam	Ahera			9c. License	000		SPD	signed (Mor	nth, Day, Year) 2006
/									- /		
5		30. Name and address of person who cor ARUNA ROK 31. Date filed (Month, Day, Year)  SEP 2 2 2006	npleted cause of dea	th (Item 23a) (1	Type, Print)	1.	1 1 ^	0 11			10

			1 - State Amend Item 5	State of Maryla per F.H., G85	nd / Depa 9,09/26	artment of	Health and Death	d Mental Hy	giene Reg. No.	06 30121
	Physic	an	Decedent's Name (First, Middle, Las.	)	_			2. Date of De Month	Dav	3. Time of Death
	/Medi	cal	Anna L. Ho 4a. Fecility Name (If not institution, give	rine		45 Cit T-			1	2006   8:20 a M
	Examir	ner	1255 Halstead Ro	ad		Par	or Location of D			ltimore Co.
L	Funeral Director		5. Social Security Number  6. Se  214-09-3936  Usual Residence of Decedent		last birthday) Yrs.	If Under 1 Yea Months Days		frs. 8. Date of Birt fin. (Month, Da Aug. 2.	, 1915	9. Birthplace (State or Foreign Country) Maryland
	he Maryland 8a-f ehow ollfled at	Director	<u> </u>	more Co.	ity, Town or Lo	ville				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or 2	al Dire	1255 Halstead Ro	ad		10f. Zip Code	21234		10g. Citizen of W Unite	hat Country? d States
920	72 hours after deeth with the Maryland nstural', or Items 23a or 28a-1 ehow disal Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🛣 No		(Specify Yes or No- lerto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
Maryland 21215-0036	s within jene. r than	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12 yrs.	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retin Purchase	ed) during most of	working	Maryland Club	iness/Industry d Automotive
yland;	be file tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last) Robert M. Rupp				Edı		eigman	
, Mar	nd 2 sh lith and 27 is m r treum		19a. Informant's Name/Relationship (T) Mr. Robert M. Hori		19b. Mailir 1255	ng Address (Stree Halstea	d Rd.	Baltimore,	r, City or Town, S MD 212	
Baltimore,	Pages 1 and the south of the so		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cren	sition (Name of natory or other place)		Date /21/2006		Sity or Town, State Maryland
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Euneral Service Licens		napp 22	. Name and Addr	ess of Facility		13	DSU York Rd. Dwson, MD 21204
	Physician /Medical Examiner	if	23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	ne cause on each line.	quence of):	er the mode of dy	ing, such as card		rest,	Approximate Interval Between Onset and Death
68760,	ificate be executed physicien and ss the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect						
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	Ectopic pregnand Other (specify)	cy		23d. Date Mont	
rds, P	v requires thet been signed t should be det	ed by P	Part II. Dther significant conditions con Afternitient a cond.	s 1	sulting in the ur	6 /te source				ute to the cause of death?
Division of Vital Records,	: The law re cate hes be , page 2 sho	Complet	multiple compression	(metures				24a. Was a autops perfor 1 Yes	sy pri med? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 \( \subseteq \) No
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?	lospital:		0		eath Check only or		
ou of	iding Phys th. After this funeral di	tlon; To	1 ☐ Yes 2 ☒ No '  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		Home 5 Residence 128d. Describe he	ence 6 Other	
Divisi	To the Hospitel or Attending Physician: The I within 24 hours efter death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre fy)			28f. Location (Si City or Town	treet and Number n, State)	or Rural Route Number,
	he Hospi n 24 hour ne Funer stely fill.	Medical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	nician: To the best of my known or: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the trestigation, in my	ime, date and pla opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
	Vithi To t	Σ	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (	Month, Day, Year)
			• (/) W	Mo.		D41	476		09.20.	500 6
_	5		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, F CHARLE,	Print) S. J. , Shi	TE 416 , B	ALTIMORE	, MD 7	11204
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2, 2, 2006	22. Registrar's Signa	ature	ري				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 30122 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Day 18, 2006 Mars Florence 11:22 MP 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. Cily, Town, or Location of Death 4c. County of Death Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days 1 M 2 032-18-336 Massachusett Yrs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 □ Yes 2 D No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Moth ks Name (First, Middle, Maiden Surname, 7000 19b. Mailing Address (Street and Number or Rural Route Number, City or To Janis Irochaska 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other) Date City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 23a. Part 1. Enter the diseas shock, or heart failure. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death E DAYS Immediate Cause (Final disease or condition CEREBROVASCULAR ACCIDENT

/Medical Examiner inding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show any injury or other traumatic event, the Middical Examination to inciting at once.

Physician

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be 2

resulting in death)	d					
ſ	Due to (or as a conseq CEREBROVA		DISEASE			5 YEARS
Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):				-
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HVDEDTENC	STUE COD	DIOMYOPATHY			
that initiated events resulting in death) Last	Due to (or as a consequence		DIGHTOPHINT			
l	d					
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ıncv			004 8	
in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown		c pregnancy (specify)		23d. Date of de Month	Day Year
Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underlyin	o cause given in Part I.	23e. Did tobacc	use contribute t	to the cause of death?
			g cases grown and and	1		Probably 4 ☐Unknown
				24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of s 2000
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 -	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 Residence	6 ∏Other (Spe	ecify)
27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in		,
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fac	tory, office	28f. Location (Street City or Town, Sta	and Number or R	tural Route Number.
29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam one)	ysician: To the best of my kno- niner. On the basis of examinal and manner stated.	wledge, death occur tion and/or investigat	red at the time, date and place tion, in my opinion, death occ	e, and due to the cause urred at the time, date a	s) and manner and place, and du	s stated e to the cause(s)
29b. Signature and title of certifier	4.6		29c. License number	29d. [	ate signed (Mon	th, Day, Year)
> /// 2. M	M.D.		D38570	Nox	+ 19,2	

OSLER DRIVE

TOWSON, MARYLAND 21204

Registrar DHMH 17 Rev 1/2001

State

7601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

JEFFREY E SELL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 30123

		1- For State Certificate of Death		Reg. N	lo.	00 0012
Physicia	an/	1 Decedent's Name (First, Middle, Last)		Date of Death Month Da	y Year	3. Time of Death
Medical Exami	ner			September 18	3, 2006 4c. County of D	0825 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Lo  3551 Sweet Air Road  Baltimore	ocation of Death		4c. County of L	eam
Funeral			If Under 24Hrs 8	B. Date of Birth (M	M/DD/YYYY) 9	Birthplace (State or
Director		413-29-0118 TXM 2 F 34 Yrs Months Days	Hours Min.	10-22-	-1971 F	oreign Country) NY
	ł	Usual Residence of Decedent				
any	1	10a State 10b. County 10c. City, Town or Location				10d Inside City Limits
and show nce.	5	MD Baltimore City	y			1 X Yes 2 No
ne Maryland or 28a-f show <u>fied at once.</u>	Director	10e. Street and Number 3551 Sweet Air St. 10f. Zip Code 21	1211	10g (	USA	Country?
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once					ODA	
th wit ems 2	Funeral	11. Marital Status 1 X Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa If Yes, specify Cuban, Married 14. Marital Status 15. Married 15. Married 16. Married 17. Married 17. Married 17. Married 18. Married 18. Married 18. Married 19. Married			14 Race - A White, e	merican Indian, Black, tc.
er dear	ᇍ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2XX No	enecify		Specify:	White
rrs aft ural"	<u>5</u>	or Dates.  15. Decedent's Education (Specify only highest grade completed)  16a Decedent's Usual Occupation	· · ·	done 16	o. Kind of Busin	
72 hot	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		)		
036 ithin and ne.	du	1 Truck Driver	r		Comme	rcial
215-0036 be filed within ntal Hygiene, rked other tha ent, the Medie	Ŝ	17.1 = 11.1 (1.1 - 1.1 -	Mother's Name (Fin			
) 21215-0036 nould be filed within 72 hours after d Mental Hygiene is marked other than "natural", or ite event, the Medical Examiner m	Be	Robert Clifford Junceau  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street a				Note 7 Code
□ s a r s l	၉	Robert C. Junceau/father   251 Tahoe Di				
ore, M ss 1 and 2 of Health If item 2	1	20a. Method of Disposition 20b. Place of Disposition (Name of ceme	etery, Da	ate 20	c. Location - Cit	ty or Town, State
Baltimore, permit Pages 1 a Department of He Important: If ite	11	1 Burial 2 XXCremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Chesapeake Crema	atory 9/	/23/06	Belts	sville, MD
Baltimc permit Page Department Important: injury or otl		4 Donation 5 Other Specify CITES A PEAR COLLETING 21. Signature of Funeral Service Licensee 22. Name and Address of	of Facility CAE	Δ	5020.	21286
Balt permit Depart Impor injury		Lands Sug Ritter MO1443 8717 Green	n Pastur	res Dr.	Balt:	imore MD
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su failure. List only one cause on each line.	uch as cardiac or re-	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical ⊆xaminer		Immediate Cause (Final disease a. Asphyxia				Death
		or condition resulting in death)  Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
/	Examiner	cause. Enter Underlying Cause (Unsess or Injury that Initiatival County English Indiatival Due to (or as a consequence of).				
d d d	Ĕ	events resulting in death) Last Due to (or as a consequence or).				
50, te be executed ysician and burial - transit	n/Medical	UNPENDED AMENDED				
760, freate by physical the bun	ğ.	IF FEMALE: 23c. If yes, outcome of pregnancy			23d Date of de	1
Sox 687 death certifit e attending	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy	′	Month	Day Year
Box 68760 e death certificate b the attending physi ed for use as the bu	Physicial	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown				
O. B at the de d by the tached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tobac	co use contribut	te to the cause of death?
, P.C res that signed be deta	d by			1 Yes 2	<b>✓</b> No 3	Probably 4 Unknown
ords, w requir	ete			24a. Was an autopsy		re autopsy findings available r to completion of cause of
Reco The law icate has	Completed			performed		th? Yes 2 No
tal Rection: The certificate	Be C	25. Was case referred to medical 26. Place of	of Death (Check only	y one)	1	
Vital F hysician: this certifi I director,	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	ther 4 Nursing H		idence 6 🗸 (	Other Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	ᇤ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury FOUND: 1 Natural 5 Pageting FOUND: 1 Yes	- Su	id. Describe how ibject involve		tic activity
Sior Affend death ctor: y the	atic	Pending  Accident Investigation Sep 18, 2006 0820 hrs	s 2 V No			
Divis  Divis  Depital or A  Hours after  Ineral Dire  y filled in b	Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse		or Town, State 51 Sweet Air	)	or Rural Route Number, City
ospits hours unera ly fills		23d. Utilities 4 Continue Physician Physician. To the heat of my knowledge, death accurred at the time, date				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d				
To wit	Me	and manner stated.  29b Signature and title of certifier  29c License of Certifier	number	29	d. Date signed	(Month, Day, Year)
		(0, (2,110)-AC) 0.C.M.	l.E.	s	eptember 1	9, 2006
j		30. Name and address of person who completed cause of death (Item 23a)		10.00		
_ 1		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 2120	1		
	tate					
Regis	ucli	SEP 2 2 2006   Blown D. James				

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SCD **Physician** 19:10P M \e. ACKSON 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Centel Year If Under 24 Hrs. Ba ohns 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. ØM 2□ F 44 Director 149-54-7862 Yrs 11/01/1961 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23 a or 28s-1 show any injury or other treumatic event, the Medical Exactings must be notified—anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore Dundalk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2955 Cornwall st. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 A Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Fast Food Elementary/Secondary (0-12) College (1-4or 5+) Cook 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne Jackson/Wife 2955 Cornwall St. Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Sep 23 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau≢e on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Hemorrnagic 3 days Physician /Medical Due to (or as a consequency of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit physicien and resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the e 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 1 ☐ Yes 2 10 No Certification: To 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation nerel Director: A filled in by the fi 1 ☐ Yes 2 ☐ No death 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 - Homicide 1 Certifying Physician: To the heet of my knowledge. Seath conumed at the time data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MP05432 Model 4940 Entern Ave Baltimore, MD 21224 RDO 31. Date filed (Month Day. 32. Registrar's Signature State Registrar

			For State Registrar	State of Maryland / De	partment of Health and	Mental Hygien	ne 2006 30125
	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)		Ortinodio or Bodin	2. Date of Death	Day Year 3. Time of Death
	/Medic Examir	al	4a. Facility Name (If not institution, give : MERCY MEDICAL		4b, City, Town, or Location of De		21 ZOOG 02:02111 Ac. County of Deeth BATTMORE CITY
*	Funeral Director		5. Social Security Number  6. Sep  1 Security Number  1 Security Number  1 Security Number  1 Security Number	7. Age (In yrs. last birthda Yrs.	Months Dave Hours M		9. Birthplace (State or Foreign Country) 206 MARY LAND
	e Maryland ta-f show	ctor	10a. State 10b. County  MD BALTIMO	RE RANDA	LUSTOW M		10d. Inside City Limits 1 ☐ Yes 2 X No
	ours after death with the Marylar ral', or Itams 23a or 28a-1 show Exammer must be notified at	Funeral Director		FE CT APT 10 2  12. Was Decedent Ever in U.S. 1			Citizen of What Country?
980	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show dical Exama sermust be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put</li> <li>Yes 2 No Specify:</li> </ol>	erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036	within ene. than	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) (Gi	cedent's Usual Occupation ive kind of work done during most of v b. DO NOT use refired)	vorking 16b.	Kind of Business/Industry  EN Fan F
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last)  UNKNOWN		18. Mother's N	ame (First, Middle, Maide STEN FO	•
-	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty, CHRISTEN FORD) 20a. Method of Disposition	350	ailing Address (Street and Number or 29 DLCLIFFE sposition (Name of	CT RANDA	LLSTOWN, MD 21133
Baltimore	permit. Pages. Department of the importent: If ite any injury or of once.		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Removal from State	rematory or other place)  LThedrol  22. Name and Address of Facility	-29-04 3 Fradley - Ad	1 11
*	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not do not east on each line.  a. Due to (or as a consequence of):	2/34WillewShapener the mode of dying, such as card ONGENITAL A	ac or respiratory arrest,	Approximate Interval Between Onset and Death
1760,	ite be execu ed iysician and ne burial-transit	cal Exan iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	ANO PALA	TE	10,44
.O. Box 68	that the death certifical ed by the attending phidetached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	The law requires that ite has been signed b bage 2 should be deta	by	Part II. Other significant conditions con	stributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
Vital Records,		Completed				24a. Was an autopsy performed? 1 □ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 No
o	Attending Physician: The death. sctor: After this certificate by the funeral director, pages	tlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Suppatient 2 ER/Outpatient 2 ER/Outpatient 28a. 0 ate of Injury (Month, Day Year) Injury	ient 3 DOA Other: 4 Nursing of 28c. Injury at	Home 5 Residence 28d. Describe how inju	
Division		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street a City or Town, State	and Number or Rural Route Number, fe)
	To tha Hospital or within 24 hours after To tha Funerei Dir completely filled in	edical	one)	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc-	ce, and due to the cause(s curred at the time, date an	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the Comple	Σ	29b. Sing furry and title the triffier	en pos	29c. License number D-43-985		ate signed (Month, Day, Year)
.4	•		30. Name and addr as of person who con 301 ST PAUL PL 31. Date filed (Month Pay, Year) 201	mpleted cause of death (Item 23a) (Typ  THE 12TT MORE  OC 32. Registrar's Signature	e, Print)  (ATYLAPVI)	Susta J.	21/2006 DULKERIANIAN
	Sta Registr	-	SEP 2 2 20	Ub proposed to			

Mechthild Louise Jordan

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 30127

Physician/ ical Examiner  1. Decedent's Name (First, Middle, Last)  Mechthild Jordan  4a. Facility Name (if not institution, give street and number) 11409 Columbia Pike Apt D6  4b. City, Town, or Location of Death 11409 Columbia Pike Apt D6  Funeral Director  5. Social Security Number 2. Date of Death Month September 9, 2006  4c. County of Death Montgomery  4d. County of Death Montgomery  7. Age (In yrs. last birthday) Months Day Hours Min.  Funeral Director  6. Sex 219-54-6410			For State	Certi	ficate of	Death			Reg	. No.	300	3012
14-00 Columbia Pike Api D6   Silver Spring	Physiciar dical Examin	<b>/</b> 1	. Decedent's Name (First, Middle,Last)	an					Date of Death	Day Year 9, 2006	154	
219 - 54 - 64 10    U XF   64   Vr.		4		et and number)	4							
The state of the part of the			219-54-6410			<u> </u>				F	oreign	(State or <b>Germ</b> a
The part of the pa	<b>Š</b>	1	0a. State 10b. County		own or Location	on	Silver	Sp	ring			
White description of the properties of the prope	the Marylan or 28a-f			Pike Apt D6	5				100		-	
20a. Mentod of Disposition   D	or items		1 Never Married 2 Married 1	Armed Forces? Yes 2XXNo	If Ye	es, specify (	Cuban, Mexican, F			White, e	tc.	
20a. Mentod of Disposition   D	36  in 72 hours af  than "natural' dical Examina	ਠ⊢	15. Decedent's Education (Specify only his Elementary/Secondary (0-12)	ghest grade completed)  College (1-4 or 5+)	16a. Decedent	's Usual Od ost of workin	cupation (Give kir ig life. DO NOT us			16b. Kind of Busin		
20a. Mentod of Disposition   D	215-00 e filed with al Hygiene ced other t								rst, Middle, Ma		nk.	
Physician Modified Washington Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Part II. Other significant conditions Page 2019 Page	MD 212 2 should be h and Ment 27 is mark imatic ever		19a. Informant's Name/Relationship (Type, Wiltrud Erhardt	Print) / Sister								
23a Part Little the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart spread and proving the following the follo	IMOFE, N Pages I and nent of Healt ant: If item or other trau		1 Burial 2 XX remation 3 F	Removal from State Bay	matory or oth View	er place) Cre	matory	09	/21/2	006 Bal	timor	e MD
The state of the s		1			115	UIE	. Fort	Avei	nue, E	3a⊥tımo:	re MD	21230
Uniform the part of the part	Medical	į.	failure. List only one cause on each li Immediate Cause (Final disease a. Hyp	<sub>ne.</sub> pertensive Atheroscle	rotic Cardio			ulac of Te	apriatory arres	st, shock, of fleat	Betw	veen Onset and
Top Day Day   Top Day Day Day Day Day Day Day Day Day Day		ler 	if any, leading to immediate Due	to (or as a consequence of):							-	
The property of the past 12 months?    Second Column 1	ansit ansit		(Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):								
25. Was case referred to medical examiner?  1	e be exec	ledica					-			1 22d Date of do	divory	
26. Place of Death (Check only one)  25. Was case referred to medical examiner?  1	Sox 6876 leath certificat e attending ph for use as the		3b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of dear	2 Fet			regnancy	<i>'</i>		_	Year
25. Was case referred to medical examiner?  1	P.O. E es that the digned by the	र्व	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying ca	ause given in Part	I.			4	(
25. Was case referred to medical examiner?  1	ecords, he law require ate has been si age 2 should b	ompleted							autops perform	y prio	or to completi hth?	on of cause of
Natural 5 Pending Investigation 3 Suicide 4 Homicide 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 21, 2006	al R					26	<del></del>	heck only	one)			Lanced .
Natural 5 Pending Investigation 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  September 21, 2006	f Vit Physic er this c	٥,	1 ✔ Yes 2 No	I Inpatient Z E			, , , , , , , , , , , , , , , , , , ,				Other: Scene	
Solicide 1 Suicide 2 Suicide 4 Homicide 6 Gould not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  September 21, 2006	<b>~</b> ≟ . ` ≃	ation:	1 Natural 5 Pending	(Month, Day,Year)			Yes 2 N	io				
290. Signature and title of certifier  O.C.M.E. September 21, 2006  30. Name and address of person who completed cars of death (Item 23a)	DIVIS spital or A ours after neral Directilled in by	( ) H	4 Homicide determined		ne, farm, stree	et, factory, o	ffice building, etc.	28			or Rural Rou	te Number, City
290. Signature and title of certifier  O.C.M.E.  September 21, 2006  30. Name and address of person who completed cars of death (Ifem 23a)	the Hos in 24 h the Fur		Check only   Certifying Physician:	To the best of my knowledge the basis of examination and	e, death occurr d/or investigati	red at the ti	me, date and place pinion, death occu	e, and du irred at th	e to the cause e time, date a	(s) and manner as nd place, and due	started. to the cause	e(s)
30. Name and address of person who completed cars of death (Ifem 23a)	To 1	Med	and	I manner stated.								
)	2		Theoden 4.  30. Name and address of person who com	Noteted cares of death (Item 2	Ce. (1)		D.C.M.E.			September 2	1, 2006	
	2					111 Pen	n Street, Balti	more, l	MD 21201			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 30128 State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4:30PM SEPTEMBER 15,2006 4a. Facility Name (If not institution, give street and number) b. City. Town, or Location of Death 4c. County of Death Itimore 7. Age (In yrs. last birthday) Olta emoria If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/3/192 Birthplace (State or Foreign Country) 5. Social Security Number Days Months Hours 1 M 2 □ F 219-01-4270 Yrs. Mary Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No altimore Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 OUSIE 212 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) overnment labore 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place)
EUCHS Funer A 20a. Method of Disposition 20c. Location - City or Town, State September 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest 4 ☐ Donation 5 ☐ Other (Specify) 18,2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Evans FunerAl Chapel Parkville Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

**Physician** /Medical

Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

al Examiner	S CC th
Ilcation; To Be Completed by Physician/Medical Examiner	1F 2
mpleted by P	Pa
To Be Co	2
lcation:	2

Medical Certi

For Stete Registrar

10a. State

11. Marital Status

1-

**Physician** 

/Medical

Examiner

**Funeral** 

Director

in than "natural", or Itema 23a or 28a-f ehow The Medical Examiner must be notified at

9

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 908g.

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be ဥ

	rooditaly at doubtry	Due to (or as a consequence of):								
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequence of):								
ical Exar	that initiated events resulting in death) Last	c Due to (or as a consequence of):								
nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pro 4 Pregnant at time of death 5 Other (spo								
7	Part II. Other significant conditio	s contributing to death but not resulting in the underlying ca	ause given in Part I. 23e. Did tobacco use contribute							

3 Probably 1 ☐ Yes 2 ☐ No

							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2
25. Was case referred to	medical	-2000/117///			26. Pla	ce of De	ath (Check only one)	•
examiner? 1 🗌 Yes 2 🗫	F	Hospital: 1 Unpatient 2	ER/Outpatient	3 🗆 נ	OOA Other: 4 🗆	Nursing H	lome 5 ☐ Residence 6	Other (Specify)
27. Manner of D th  1 Natural 5  2 Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. injury at Work? 1 ☐ Yes 2 [	□No	28d. Describe how injury	occurred
	Could not be	28e. Place of Injury - At h	ome, farm, street	lacto	nv office		28f. Location (Street and	Number or Rural Route Number.

to the cause of death?

4 Unknown

27. Manner of Doth 1 SaNatural 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 □No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, lac	tory, office		28f. Location (Street and Number or Rural Rout City or Town, State)

29a. Certifier (Check only one)	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature SEPTEMBER 15, 2006 D47123 Mumana

E. UNIV. address of person who completed cause of death (Item 23a) (Type, Print) 201 PKWY. JOSEPH PUTHUMANA BALTIMORE 21218 31. Date filed (Month, Day, Year)-

State Registrar

32. Reginar's Signature

841

			For State Registrar	State of Man	yland / Dep. <i>Ce</i>	artment of H <i>rtificate of l</i>	lealth and Me Death	ental Hygien Reg. N		5 30129			
	<b>D</b>		1. Decedent's Name (First, Middle, Last,	)				2. Date of Death	ay Year	3. Time of Death			
	Physici /Medic		Angelina Mary Ko	olb				EPTEMBER	21 2006	6 10 AM			
	Examin	er	4a. Facility Name (If not institution, give	,		4b. City, Town, or	Location of Death	4	c. County of Deat	h			
			5. Social Security Number 6. Sec	SIDE	n yrs. last birthday,	Dell If Under 1 Year	A //) () If Under 24 Hrs.	R Date of Birth	FIFIR PORCO	holaco (State or Formian			
	Funeral Director		214-05-3510	7	86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 21,1	920 Mar	hplace (State or Foreign ountry) yland			
	and		Usual Residence of Decedent  10a. State 10b. County	10	Dc. City, Town or L	ocation				10d. Inside City Limits			
	Mary Feh	tor	Maryland Harford		Street					1 ☐ Yes 2 ☐ No			
	h the	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	ountry?			
	23a c		3300 Deerhill Road	<u> </u>		2115	4	U.S	.A.				
36	72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f ehow olicel Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ★ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	ispanic Origin? (Spec n, Mexican, Puerto R Specify:	ity Yes or No- ican, etc.)	14. Race - Ame Black, White Specify:	e, etc.			
9	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation	16b.	Kind of Business/	ite Industry			
215	s within 72 ho jiene. r then "natur the Medical	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4 or 5+)	(Give	kind of work done of DO NOT use retired	furing most of working )	g					
2		Con	8		Homer	nkaer			wn Home				
Ind	e d is b	Be	17. Father's Name (First, Middle, Last)  Carmel Scuderi				18. Mother's Name Lucy Dimi		n Sumame)				
3	3 2 2 2	P	19a. Informant's Name/Relationship (Ty	on a Defeat	105 14-11	Add (Ot				7'- O- d-1			
Maryland 21215-0036	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Charles Kolb (Son)				and Number or Rural Road, Str						
ē,	ges 1 and it of Health if item 27 or other tr		20a. Method of Disposition			osition (Name of matory or other place			Location - City or				
E	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	terrioval from State			",Inc.09/25	/2006 Bal	timore.	Marvland			
Baltimore,	permit. Page Dapartment of Importent: ff any injury or once.		21. Signature of Fundant Sources Licens				s of Facility 1ZdZinski						
<u>m</u>	90 1 9	d	1 The			1407 OLG 1	Bastern Av	enue, Ess	ex, Mary	land 21221			
				ications that caused the ne cause on each line.	e death. Do not en	ter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between			
	Physician		Onset and Death isease or condition a										
1	/Medical Examiner		Due to (or as a consequence of):										
		Jer	Sequentially list conditions, if any leading to immediate	b. Due to (or as a co	onsequence of):	1013				& posses			
18	uted	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		vaserlar	disame				Yens			
7.	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a co	-								
68760,0	ificate be executed g physicien and as the burial-transit	edicai	Ų,	d									
	ing pt	Med	IF FEMALE:	23c. If yes, outcome of p									
P.O. Box	The law requires that the death certif ate has been signed by the ettending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23d. Date of delivery  Month Day Year								
	s that ned b e deta	by Pi	Part II. Other significant conditions con	ntributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?			
rds	w require been sig should b	edit	1) pnow	sia ano	ma, de	pressing		1 ☐ Yes	2 ☐ 140 3 ☐ Pro	obably 4 Unknown			
Division of Vital Records,	The law re tate has be page 2 sho	Completed						24a. Was an autopsy performed?	prior to death?	stopsy findings available completion of cause of			
ital	(U	BeC	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2 ▼ N (Check only one)	lo 1 Yes	2□ No			
<u>&gt;</u>	hysic his ce I direk	2	examiner? 1 ☐ Yes 2 ☐ No	lospital:	2 ER/Outpatie	nt 3□ DOA Othe	ar: 4 🔯 Nursing Hom	e 5 🗆 Residence	6 □Other (Spec	cify)			
ם	or Attending Physicien: after death. Director: After this certifici in by the funeral director, i	ino i	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time o	Worl		3d. Describe how inj	ury occurred				
isic	death ctor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home form at		Yes 2 ☐ No	of Location (Compt.	and Number or Di	on I Davida Mumba-			
Ò	i or A after Direction by	Certification:	4 Homicide determined	building, etc. (\$	Specify)	геет, тастоту, оптсе	20	If. Location (Street a City or Town, Sta		irai Houte Number,			
_	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	sician: To the best of m	ny knowledge, deat	h occurred at the tim	ne, date and place, ar	nd due to the cause(	s) and manner as	stated.			
	he Ho in 24 he Fu pletel	ledicai	one)	ner: On the basis of ex and manner stated	amination and/or in 	vestigation, in my or	pinion, death occurred	d at the time, date a	nd place, and due	to the cause(s)			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11.	4	29c. License	number	29d. D	ate signed (Month	h, Day, Year)			
			, Jan	1 Mun	nn	117	1975	(	1/22/06				
	3		30. Name and address of person who co	McClynia	h (Item 23a) (Type,	Mor Mari	1 nd B	el Air	un 2101	4			
	Sta Registr	_	31. Date filed (Month Pay, 202) 200	6 32 Registrar's	Signature	all!		(					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 00.16.2006 VIRGINUA 4:15 LEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCHRIST NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 X F Yrs DC 18 Director 212.36.3580 09.08.1928 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits if Heelth and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, the Madical Exemples must be notified at 1 ☐ Yes 2 X No Director COLUMBIA MD HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8786 CLOUDLEAP CT. \* T3 21045 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LPN KESWICK NURSING CTR. 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Heelth and Mental I ant: If Item 27 Ie marked of STANLEY GIBBS JOHNSY ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8186 CLOUDLEAP CT., T3, COLUMBIA ROBERT LEE, JR (HUSBAND) MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Important: If any injury or once. GARRISON FOREST 09.26.06 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MIUS MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility VAUGHN C. GREENE FUNELAL SERVICE aughn 5151 BALTO. NATT. PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDSTAGE **Physician** cars disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Succeptially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown renal 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No Division of Vital 1 Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? After this certific funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending efter death.

Director: Aft d in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a
To the Funeral C
completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05643 16/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kendale R Faulknemid/6601 N. Charles Street/Baltimore 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 20,2006 12:28P M Physician DOLORES M. LENTZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Devember 18, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 214-22-0874 1 ☐ M 2 💢 F Ż9 Maryland Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Iteme 23a or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hyglene. Importent: If item 27 Is marked other then "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once. MD Baltimore Kingsville 1 Tyes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 16 Wildon Court USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Self-Employed 12 17. Father's Name (First, Middle, Last)
Melvin Burns 18. Mother's Name (First, Middle, Maiden Sumame) Be Betty Phyles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16 Wildon Court-Kingsville, MD 21087 Darlene Reichenbach-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place).

Moreland Memorial
Park Date 20c. Location - City or Town, State
Parkville, MD 9-24-06 1 □Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road-Parkville, MD 27234 Judo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer UNG Pnysician inwins /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (u. as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the ettending physicien and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Not PLE Certification: To 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hoepital within 24 hours a To the Funerel C completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D58303 September 20 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTHER ND 21204 6601 N. Charles 0 31. Date filed (Month, 3 32. Registrar's Signature State Registrar

Amend Items 1719 or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

Amend Items 24a, 25 per dr., C859.09/21/06dhb

Reg. No. 30133 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 5:21 PM ptember 17 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmure If Under 1 Year If Under 24 Hrs. Hodans Johns 19 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day 6. Sex Birthplace (State or Foreign Country) **Funeral** 218-62-5614 12 M 2□ F Months Days Hours marie Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1/X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö SA Wooding 238 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Blac ö 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ian toua than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Jan, tor NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Smith rado Dorothy 19a. Informant's Name/Relationship (Type, Print) - S Ster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 n. Woodington Rd. Barto, md, 21229 matthew-lea item 27 Va 41 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ਰ≝ 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. 09/23/2006 New Cathedral Baltimore, MD 4 □ Donation / \$ □ Other (Specify) 22. Name and Address of Facility Red HILTON 21. Signature of meral Service Licens Pass Balto, md, 21229 P, march Fune al Home 23a. Part / E e the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final disease of condition resulting in death) a. Hydrix Entral (or as a consequence of): Physician Calapet hours /Medical Examiner Due to (or is a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit death certificate be executed Due to (or as a conse (Jence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Dav Year 5 Other (specify) Division of Vital Records, P.O. sete has been signed by the a page 2 should be detached 9☐ Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 1 or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Certification: To 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funerel C
completely filled the Hospital 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Eler arall 30. Name and address of person who completed cause of death (Item 2 a) (Type, Print) Margaret Showel
31. Date Kild (Month, Day, Year) The Johns Hodgers Hospital GOON Wate ST 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

SEP 2 1 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.0 6.

			For State Registrer	State of Ma	ryland / Depa	artment of H	lealth and M Death	Re	g. No.	30134	
	Physici	an.	Decedent's Name (First, Middle, Last)					<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death	
	/Medic		Thelma Leimkuhler					Sept 16,		10:40 am M	
	Examin	er	4a. Fecility Name (If not institution, give s Manor Care	street and number)			Location of Death		4c. County of Dea		
			5. Social Security Number 6. Sex	7 Age	(In yrs. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Bir		
	Funeral Director			M 2DE	92 Yrs.	Months Days	Hours Min.	Month, Day,		thplace (State or Foreign cuntry)	
	ס		Usual Residence of Decedent								
	ahow	_	10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	Ba-f s	ct	MD Baltimore		Towson						
	with th	Dir.	10e. Street and Number	له م		10f. Zip Code 21286			og. Citizen of What Co	ountry ?	
	s 23	erai	509 East Joppa Ro	12. Was Decedent E	verin IIS 13		ispanic Origin? (Spe		U.S.A.	erican Indian.	
40	fter d	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 3 N If Yes, Give	0		ispanic Origin? (Spe an, Mexican, Puerto i	Rican, etc.)	Black, White		
036	al', o		3 N Widowed 4 Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes 2 █ No	Specify:		Specify: Gat	icasian	
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Exam, or must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup	during most of workir	ng	16b. Kind of Business	/Industry	
21	Althin han *	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	1)		0 11		
121	tygiel ther th		5th grade  17. Father's Name (First, Middle, Last)		Homen	laker	18. Mother's Name		Own Home		
and	antal h	) Be	Gottleib Lizau				Ida Race		,		
Maryland	Should Me mark	10	19a. Informant's Name/Relationship (Ty	рө, Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number,	City or Town, State,	Zip Code)	
Ž	alth a 27 is 27 is or trau		Doris Munshi, dau	ghter	9608	Amberlei	gh, Unit K	, Perry	Hall, MD	21128	
Je,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Example must be notified at 2008.		20a. Method of Disposition	la-rand from Chata	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	ce) D	ate 2	20c. Location - City or	Town, State	
Ë	Page nent ant: If ury o		**XSurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc.								
Baltimore,	permit. Departi		21. Signature of Funeral Service License	88							
	<u>0</u> 0 = 0		1/m	6415 Belair Road, Baltimore, MD 21206  Approx  Approx  Approx							
			shock, or heart failure strong or small shock or heart failure strong or Immediate Cause (Final	ne cause on each lin	e.	er the mode of dyln	ig, such as cardiac o	r respiratory arre	est,	Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	1)cmc	ntia					years	
	Examiner			Due to (or as a	a consequence of):						
	26	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Crisses of injury	Due to (or as a	a consequence of):						
ف	cuted od ransit	Examiner	trial initiated events	o							
Ö,	e exe ian a urial-1		resulting in death) Last	Due to (or as a	a consequence of):						
8760,	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		d							
9 ×	ding p	/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of de	livery	
Box	death e atten	cian	in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)	/		Month	Day Year	
P.O.	that the de ned by the a detached t	ıysi	1 ☐ Yes 2 <b>⑤</b> No 9 ☐ Unknown	9□Unknown							
	w requires that been signed b should be det	by P	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?	
rg	requires t een signe routd be	edi						1 🗆 Ye	s 2 Q_No 3 □ P	robably 4 Unknown	
ecc	10 m CA	Completed						24a. Was ar autops	v prior to	utopsy findings available completion of cause of	
8	T+ ate pa	Con						perform 1 ☐ Yes 2	ned? death?	2 <u>No</u>	
1 \ Yes 2 \ No \ \ 25. Was case referred to medical examiner? Hospital: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \											
of	Phys this al di	To.	1 ☐ Yes 2 ☐ No '	Hospital: 1 ☐ Inpatie			41.3 Hursing Hor		nce 6 Other (Spe w injury occurred	ecify)	
O.	fter fter	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	Year) Injury	Wor	k? Yes 2□No		,,		
Division of Vital Records,	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, st	reet, factory, office			reet and Number or R	ural Route Number,	
Ö	s after	Certification:	4 Homicide	building, etc	с. (Бресіту)			City or Town	, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai (			of my knowledge, deal examination and/or in ited.						
	To th Within To th	₹	29b. Signature and title of certifier		-	29c. Licens	se number		9d. Date signed (Mon		
	-		Joso Blass	mo		10061	199	5	ept, 19,20	200	
	N		30. Name and address of person who co				2 1				
	* 1		Jason Black und	, 6565 No.	14 Charks	ST, Suite	209. 70	w50 m 1	402120	4	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2: 2, 200	6 Registra	ars Signature	cell!					

DHMH 17 Rev 1/2001

Patient Known as Martin, Marge.

Baltimore. Maryland 21215-0036

		For State Registrar  1. Decedent's Name (First, Middle, Last)	Department of Health Certificate of Death		Reg. No. 200	6 30   3
Physicia /Medica	al	Marguerite Estelle Martin	th Ch. Tour and applied	Sept.	15, 20	06 7:00 PM
Examine Funeral Director	er	4a. Fecility Name (If not institution, give street and number)  Sinai Hospital of Baltin  5. Social Security Number  218-44-3064  5. Sex 1 □ M 2 ☑ F  7. Age (In yrs. last	Ab. City, Town, or Location  BaHmore  Birthday)  If Under 1 Year  Months Days Hours	e City	4c. County of D	eath  Birthplace (State or Foreign Country)
e Maryland e-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, To MD Baltimore City Balti	own or Location			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
h with the	ai Dire	10e. Street and Number 4204 Tuscany Court	10f. Zip Code 21218		10g. Citizen of What United St	
	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)		merican Indian, /hite, etc. nite
2 should be filed within 72 hours aft and Mental Hyglene. Is marked other than "netural", or raumatic event, the Medical Exami	Completed by	(Specify only highest grade completed)	Ga. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) Ingineer	st of working	16b. Kind of Busine Defense	ess/Industry
d 2 should be file th and Mental Hy ?7 is marked othe traumatic event,	To Be C	17. Father's Name (First, Middle, Last) LeRoy Peter Baum	18. Moth	ner's Name <i>(First, Middl</i> e, guerite Estel	Maiden Sumame) le Kearns	
nd 2 shot lith and N 27 is mai r trauma		19a Informant's Name/Relationship (Type, Print) Mrs. Mary JoAnne Walz/Sister	9b. Mailing Address <i>(Street and Numb</i> 6 Far Corners Loop	per or Rural Route Number p Sparks Gle	er, City or Town, State	e, <i>Zip Code)</i> 21152
g e tr		1 Rurial 2 Cremation 3 Removal from State	of Disposition (Name of tery, crematory or other place)	පීළුp 19 2006	20c. Location - City 'Bethesd	
permit. Departi		21. Signature of Funeral Service Licensee	Rapperunersidad 933 Gist Ave. S			20910-
Price De	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the c	ce of):	met John By ME	OICH EXAMINER	Interval Between Onset and Death
The law requires that the death certificate tale has been signed by the attending physic page 2 should be detached for use as the tale.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal dea 4  Pregnant at time of death		morro.	23d. Date of Month	delivery Day Year
w requires that s been signed b should be deta	ed by Pl	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part			e to the cause of death?  Probably 4 Unknown
ician: The law requires to certificate has been signe rector, page 2 should be	0	25. Was case reterred to medical	26 Plan	24a. Was autor perfo	prior prior death	autopsy findings available to completion of cause of ?  es 2 No
ding Phys	Certification; To B	27. Manner of Death  1	Outpatient 3 DOA Other: 4 N.  D. Time of Injury at Work?  1 Yes 2 farm, street, factory, office	ursing Home 5 Residence 28d. Describe h	dence 6 Other (S	Bicycle
To the Hoscitel or Attention within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowled and manner stated.	Dad way Ige, death occurred at the time, date an and/or investigation, in my opinion, dea	nd place, and due to the ath occurred at the time,	les 5+/H cause(s) and manner date and place, and c	omeland Ave as stated.  due to the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number	958	29d. Date signed (Mo	nonth, Day, Year)
1,2		30.   a     a d'addless of person   e completed o use of a ath (Item 23a	a) (Type, Print)	Hestifal		
State Registra	-	31. Date filed (Month, Day, Year) 32/Registrar's Signature	Sparke	/		

6-07108 Please Type or Print in Black Indelible Ink										
eggy Jean Martin	St 1- For State Registrar	ate of Maryla	and / Departme Certifica			Menta	Hygiene	Reg. No.	200	6 3013
Physician/ Medical Examine	1. Decedent's Name (First, Midd Peggy Jean	Martin						Day ber 20, 200		3 Time of Death 0910 hrs
	4a. Facility Name (if not institution Governor Bridge Rd n		,		City, Town, or Li Davidsonville		eath		nty of Dea Arunde	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birth	nday)	If Under 1 Year	If Under 2		Birth(MM/DD/Y	YYY) 9. B Fore	irthplace (State or
Director	236-52-2311 Usual Residence of Decedent	1 M 2 X F	71	Yrs.	Months Days	Hours	Mar.	27, 193		ountry) WV
with the Maryland s 23a or 28a-f show any e notified at once.	Maryland Anne  10e. Street and Number	Arundel	10c. City, Town	onvil	.le 10f. Zip Code			10g. Citizen o	f What Co	10d. Inside City Limits 1 Yes 2 No untry?
or item:	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div	arried 12. Was Dec Armed For 1 Yes vorced If Yes, Give Yes or Dates:	edent Ever in U.S orces? 2 X No	If Yes	21035 Decedent of Hisp, s, specify Cuban, l	Mexican, Pu	uerto Rican, etc.)		Vhite, etc. hify: <b>W</b>	erican Indian, Black,
21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural", event, the Medical Examiner To Be Completed by 1	Elementary/Secondary (0-12)		-4 or 5+)		st of working life. [			Flor		simoustry
21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica					18	3.Mother's N Luna	lame (First, Middle Alice	e, Maiden Surn	ame)	
re, MD 1 and 2 sho F Health and F item 27 is er traumati	19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State   Linda Austin / Daughter   630 Governor Bridge Road, Davidsonvill   20a Method of Disposition   20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State   4 Donation 5 Other Specify: Hilltop Service Corp. 9-22-06 Towson, Mailing Address (Street and Number or Rural Route Number, City or Town, State   20b. Place of Disposition (Name of cemetery, crematory or other place)   Date   20c. Location - City or Crematory or other place)   Towson, Mailing Address (Street and Number or Rural Route Number, City or Town, State   20c. Location - City or Crematory or other place)   Date   20c. Location - City or Crematory or other place)   Towson, Mailing Address (Street and Number or Rural Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number, City or Town, State   Control Route Number or Rural Route									le, MD 21035 or Town, State
Baltimo permit Pages Department of Important: I	Signature of Funeral Service	Licensee		22 Na MC	me and Address of Comas Fu 17 Cokes	neral	Home, P	.A.		
Physician /Medical Examiner	23a. Part (. Anter the disease, or failure List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.  a. Head and s	shoulder injuries a consequence of):	t enter the	e mode of dying, s	uch as card	ac or respiratory	arrest, shock, o	r heart	Approximate Interval Between Onset and Death
fed insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death). Last Due to (or as a consequence of):									
executed in and il - transit	events resulting in death) Last  UNPENDED	dAMENDED	сопвециеное оп.							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiperial Certification: To Be Completed by Physician/Medical Expedical Certification: To Be Completed by Physician/Medical Expedical Certification: To Be Completed by Physician/Medical Expedical Certification: To Be Completed by Physician Medical Expedical Certification: To Be Completed by Physician Medical Expedical Certification: To Be Completed by Physician Medical Expedical Certification of the Completed by Physician Medical Expedical Certification of the Completed by Physician Medical Expedical Certification of the Completed by Physician Certification of the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)							•	
, P.O. Erres that the casing by the bedetached		tions contributing to	o death but not resulting	in the un	derlying cause giv	ven in Part I				o the cause of death?
tal Records, I cian: The law requires certificate has been sig ector, page 2 should be			·				ре	as an 24 Intopsy Informed?		
ital   sician: s certifi irector.	25. Was case referred to medical examiner?	Hacnital:	Inpatient 2 ER/Ou	utpatient		ther -	eck only one) ursing Home 5	Residence	e of Oth	or Sanna
Division of Virpital or Attending Physical or Attending Physicals ours after death.  Beral Director: After this filled in by the funeral director.  Certification: To	27 Manner of Death	28a. Date	of Injury 28b. 7 Day, Year) FOU	Γιme of Inji	ury 28c. Injury		28d Descrit	pe how injury oc to auto collis	curred	er, ocerie
Division o ospital or Attending hours after death. uneral Director: After y filled in by the firme Centification:	3 Suicide 6 Cou	ld not be 28e. Plac	e of Injury - At home, fa	rm, street,	, factory, office bu	ilding, etc.	or Towr	n, State)		Rural Route Number, City awberry Run, David
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		miner: On the basis and manner s	et of my knowledge, dea of examination and/or in stated		on, in my opinion,	death occur				
	29b. Signature and title of certific	er			29c. License O.C.N			29d. Date	-	onth, Day, Year) 2006
8	30. Name and address of person who completed cause of death (item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									

State Registrar

31. Date filed (Month, Day, Year) SEP 2: 2 2006

32. Registrar's Signature

	1 - For State Registrar	tate of Marylan	nd / Department of I Certificate of	Health and M Death		iene 2006	30137	
Physiciar	1. Decedent's Name (First, Middle, Last)	61			2. Date of Deat Month		3. Time of Death	
/Medica	1 G-6016-C		rrax	or Location of Death	09	14 0°6		
Examine Funeral Director	St. Thomas Moore Nu 5. Social Security Number 6. Sex		Hyattsv	ille   If Under 24 Hrs.   Hours   Min.	8. Date of Birth (Month, Day,		OTGE S thplace (State or Foreign buntry)	
o	Usual Residence of Decedent  10a. State  10b. County	10c. Cit	ty, Town or Location		July 27	1969  Wasi	10d. Inside City Limits	
e-f sh	MD Prince Geo	rge's Hya	nttsville				1 Yes 2 □ No	
or 28	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?	
s 23e	4922 LaSalle Rd	Was Decedent Ever in U	20782	Ui O-i (C		ited State		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any jury or other traumatic event. If e.M. Alfall Ex., it is for item to use the could also any jury or other traumatic event. If e.M. Alfall Ex., it is for item to use the could be any European Disocher.	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	was becount Ever in 0 Amed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		oan, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	e, etc.	
ithin 72 ho	15. Decedent's Educat (Specify only highest grade co		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of worki	ing	16b. Kind of Business	/Industry	
lled w Hygier ther th			Laborer	18. Mother's Name	/First Middle A	Private		
d be f	Coorse E Marson			Cynthia (		aloen Sumame)		
should Me Me Mark	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing Address (Stree	-		City or Town, State, .	Zip Code)	
and 2 naith a 127 is er trau	Cynthia Murray / Mot	her	305 34th St S	E #2 Washi	ington D	C 20019		
of He of He If item or oth	20a. Method of Disposition 1 ☐ Burial 2☐ Cremation 3 ☐ Rem		Place of Disposition (Name of cemetery, crematory or other pla		Date 2	20c. Location - City or		
Pag trment tant:	* 4 □ Donation 5 □ Other (Specify)		ropolitan Crem	atory	12	lexandria	Va	
Depar Impor Inn in Inn in	21 Signature of Funeral Service Licensee	Frisks		ess of FacilityPops		l Home n DC 20020		
	23a. Part1. Enter the disease, or complicat	ions that caused the deat					Approximate	
Physician	shock, or heart failure. List only one of Immediate Cause (Final	ause on each line.		_			Onset and Death	
/Medical	disease or condition resulting in death)	Due to (or as a conseq	muno defician	CY TYNOX	one / 11	11/5	years	
Examiner	Sequentially list conditions. b						-	
sit sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
physician and street be burial-transit	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.							
nding physician and use as the burial-tran	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregna				23d. Date of de	ivery	
that the death certified by the attending detached for use as	in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		у		Month	Day Year	
w requires that been signed I should be det	Part II. Other significant conditions contrib			ven in Part I.		acco use contribute to s 2 □ No 3 □ Pr		
25 2	Drabetes Me				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
ician: Sertific ector,	25. Was case referred to medical examiner?	nitai-	Ott	26. Place of Death				
To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: Attenthis certificate ha completely filled in by the funeral director, page	1 Yes 2	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wo		me 5 Resider 28d. Describe ho	nce 6 □Other <i>(Spe</i> w injury occurred	cify)	
el or Attendi s after death, il Director: A sd in by the fu	2 2 Cuiside 6 Could not be	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ro State)	ural Route Number,	
To the Hospitel within 24 hours a To the Funeral I completely filled	29a. Certifier 1—Certifying Physici	an: To the best of my kno On the basis of examina and manner stated.	owledge, death occurred at the tition and/or investigation, in my	me, date and place, a opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	
To the To the comp	29b. Signature and title of certifier	lu Ine	hn 29c. Licen	185 Z		d. Date signed (Mont		
5	Paul A. Del	leted cause of death (Item	1 23a) (Type, Print) 4 2 6 3 (a) sture					
State Registra	een a a anne	32. Pegistrar's Signa	the foods					

Registrar

		•	For State Registrar	State o	f Marylar	•	artment of F	lealth and M <i>Death</i>	fental Hygi	ene g. No. 2	006	30	139		
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Death	1		3. Time of I	Death		
	Physicia		Stanley J.	Napora	_				SE P	Day 1 🕏	2006	212	м		
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death		-	ty of Death		•		
1	Examin				Boo Low	1 (0 10	RIL				•				
			5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9 Righn	lace (State or	Foreign		
	Funeral Director			1□M 2□F		Yrs.	Months Days	Hours Min.	(Month, Day,		Coun	lace (State or try)	. o.o.g//		
	Director		220.22.1577 Usual Residence of Decedent	XX	76				MARCH 16,	, 1930	1	MD			
	and and		10a. State 10b. County		10c. C	ty, Town or Lo	ecation				1	0d. Inside Cit	y Limits		
	Aary r sho	ŏ										1 🗆 Yes	2, No		
	28a-	Director	MD ANNE A  10e. Street and Number	RUNDEL	SE	VERN	10f. Zip Code		10	Or Citizen o	f What Coun		XX		
	with a	ă	Toe. Screet and Number				Tot. Zip Code			y. Chizen o	What Cour	u y :			
	filed within 72 hours after deeth with the Maryland Hygiene. ther then "naturel", or iteme 23a or 28a-f show ther the Medical Examiliar round be multified at	Funeral	601 DONALDSON AVE.				21144				USA				
	e de	nue	11. Marital Status	Armed Fo	edent Ever in U prces?	J.S. 13.	Was Decedent of F If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ace - Americ lack, White,				
36	or t		1 □ Never Married 2 □ Marr	ied 1 ☐ Yes If Yes, Gir	2 ∏ No ve XX		1□Yes XX No	Specify:		Spec	cify:				
ğ	In all	d by	3 Widowed 4 Divorced	Year or D	ates:							ITE			
21215-0036	72 h	Completed	15. Deceden (Specify onfy higher	t's Education st grade completed)		(Give	dent's Usual Occup kind of work done	during most of work	ting 1	6b. Kind of	Business/Ind	dustry			
2	ithin	npi	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use retire	d)							
2	A G S	Ö	12			S	TEWARD			U.S. AF	RMY				
ğ	be filed stat Hygi of other svent, I	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle, M	faiden Suma	ame)				
<u>a</u>	should be filed within 72 hours after deeth with the Marylan nd Mental Hyglene. marked other then "naturel", or iteme 23a or 28a-f show imatic event, the Medical Examiliar nust be nutitied at	2	IGNATIUS NAPORA					ROSE ZACHO	WSK I						
Maryland		-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Rur	al Route Number,	City or Tow	n, State, Zip	Code)			
	and 2 seath ar n 27 is ier trau		KATHLEEN NAPORA		WIFE	601 D	ONAL DSON AV	/E. SEVERN.	MD 21144						
altimore,	s 1 and if Health Item 27 other tr	. 8	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of	-		Oc. Location	n - City or To	wn, State			
ۊ	000		1 XXBurial 2 ☐ Cremation		State	-	natory or other plac					_			
≣	tant rtant rtant		4 Donation 5 Other (S			10	OWNSVILLE	9.22.	2006	CROWNS	/ILLE, N	1D			
Ba	permit. Page Department Important: flancortant: flancortant: flancortant of any njury of onco.		21. Sign vice of Funeral Service	LIOCAL MORE	-la	FÏ	2. Name and Addre NK FUNERAL	HOME, P.A.							
_	405 € Q		K GREGORY EIN		M01148			SW GLEN BU							
			23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock or heert failure. Ust only one cause on each line.  Approximate Interval Between Conset and Death												
	Pnysician		Immediate Cause (Final disease or condition	mail	ti ora	. 41	esten C					Onset and D	eath		
1	/Medical		resulting in deal )	a. Due to	(or as a conse	quence of):	1ston to	union C				ed :			
	Examiner		Sequentially list conditions h Sep 515												
	mg - La	ē	Sequentially list conditions, if any, Jeaning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	(or as a conse	quence of):		-				4	17		
	nsit	nin	cause. Enter Underlying Cause (Disease or injury	R.	. 10 -0							6 1	ALIC		
	xecu and al-tra	Examin	resulting in death) Last	C. Due to	(or as a conse	quence of):						0 0	73		
8760,	cate be executed physicien and the burial-transit	alE		En	dace	1.160						6 1	aus		
87	cate be executed physicien and the burial-transit	dical		d	in Car	AUIIS						0	-1		
9 ×	leath certific ettending p I for use as	- ab -	IF FEMALE:	220 15 1100 011	tcome of pregr	2001									
Ö	ath c ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	1 Live t	oirth 2 ☐ Fet	aldeath 3[	Ectopic pregnancy	у			Date of delive Month	•	ear		
<u>.</u>	e de p	Sic	1 ☐ Yes 2 ☐ No	4∐Pregr 9⊡ Unkn	nant at time of	death 5	Other (specify)					,			
P.O. Box	thet the death certined by the ettending	Physiclan/M	9 Unknown												
	res the igned be del	δ	Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use co	ntribute to th	e cause of de	eath?		
Ď	w require been sig	ed	penal dise	use CM	16				1 🗆 Ye	s 2 No	3 🗌 Prob	ably 4	nknown		
8	The law requires that the death certifi ste has been signed by the ettending I page 2 should be detached for use as	Completed		•					24a. Was an	24b	. Were auto	psy findings a	vailable		
æ	he lav e has	Ē							autopsy	red?	death?	npletion of ca	use of		
a	ding Physicien: The h. h. After this certificete ha funeral director, page									□ No	1 🗆 Yes	2□ No			
Division of Vital Records,	icia certi	Be	25. Was case referred to medica examiner?	7			Ott	or	th (Check only one	-					
5	phys this al dir	ပ္	1 No 2 No	11/2	•	ER/Outpatier	II JU DOM	4 🗆 Nuising no	ome 5 Reside			1)			
<u>C</u>	ding f h. After funer	Ö	27. Manner of Death  1 Natural 5 ☐ Pendir	28a. Date (Mon	of injury oth, Day Year)	28b. Time of Injury	Wo		28d. Describe ho	w injury occi	urred				
<u> </u>	tendi death. tor: A	ati	2 ☐ Accident investi	gation		li .	M 1 🗆	Yes 2 □ No							
ž	or Attendate death Director: /	Ě	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Flace	of Injury - At hing, etc. (Spec		reet, factory, office		28f. Location (Str. City or Town,	eet and Nur State)	nber or Rura	I Route Numb	oer,		
	s aft s aft al Di ed in	Certification:								,					
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illed in by the funeral director.		29a. Certifier	ig Physician: To the	a best of my kn	ciwladge, deat	h occurred at the tir	me, data and plane	and due to the ca	usa(s) and r	marinar as st	uted			
	Pe Ho	edicai	(Check only 2 Medical one)	Examiner: On the b	nasis of examin ner stated.	ation and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ite and place	e, and due to	the cause(s)			
	To the Ho within 24   To the Fu completel	¥.	29b. Signature and title of certifie	( ) ( A			29c. Licens	se number	29	d. Date sign	ned (Month,	Day, Year)			
	2		) (1. And	XLI	hen E	endo	r n/:	2929	<	EP	18 2	.006			
,	1 -1	1	20 North	2) 12/	IVI) [	-> Wew	Crieth	ノして		F	10 2				
1	7		P. 1 1 ()	who completed cau	1	•	Shee	V Q I	<b>L</b>	MD .	רו ר	n 1			
		ď,	31. Date filed (Month, Day, Year)	1 200 5	Registrar's Sign	oreen	ے کہ وو	1 Dal	Umare	<b>ハ</b> カ	UIU	<u> </u>			
	Sta Registi			88	registrat s Sign	A Age	and a								
	negisti	al	SEP 2 2	LUUU JAKA	Salahan Su	- 45							_ ]		

		•	For State Registrar	State of M	arytanu / Depa Cei	rtificate of	Death		g. No.	30140
10	Dhusisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al .				Jr.		Septembe	r 20, 2006	
	Examin	er	4a. Facility Name (If not institution, giv				or Location of Death		4c. County of Deat	
g*	Funeral		Oak Crest Villa 5. Social Security Number 6. S		je (In yrs. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,	Baltimor	CE hplace (State or Foreign untry)
	Funeral Director		214-12-9368 Usual Residence of Decedent	XM 2□ F	85 Yrs.	Months Days	Hours Min.	April 14	$\frac{Y_{\theta ar}}{4}$ , 1921 M	aryland
	yland yland		10a. State 10b. County	, , , , , , , , , , , , , , , , , , , ,	10c. City, Town or Lo	cation				10d. Inside City Limits
	r 28a-f show	ctor	Maryland Baltimo	re	Parkvil	le				1 ☐ Yes 2 X No
	vith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	death with the Maryland ims 23a or 28a-f show if must be notified at	erai	8810 Walther Blv	d . #1009 12. Was Decedent	Ever in U.S. 13.1		21234	ecify Yes or No-	U.S	
(0	or Item	Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forces  1 ⊠ Yes 2 ☐ If Yes, Give	No		Hispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)	Black, White	
93	72 hours after netural', or ite dical Examina	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WW II	1 ☐ Yes 2 🛣 No	Specify:		Specify: Wr	nite
21215-0036	"netu	Completed	15. Decedent's E (Specify only highest gr		16a. Dece (Give	dent's Usual Occup kind of work done	oation during most of worki d)	ing 1	6b. Kind of Business/	Industry
121	within 7 ene. then "r he Med	ошо	Elementary/Secondary (0-12) 12 years	College (1-4or	5+)		Agent		Insurance	<u>,                                      </u>
	filed with Hygiene. other ther	Be C	17. Father's Name (First, Middle, Last	)	4.11	our direc	18. Mother's Name	e (First, Middle, M		
Maryland	should be filed within and Mental Hygiene. marked other then imatic event, the M	To B	Walther Frederick	Nehrenz,	Sr.		Alvina I	da Schra	der	
lar	s 1 and 2 should Health and Mer Item 27 le marke other traumatic		19a. Informant's Name/Relationship (			•			City or Town, State, 2	
	1 and Health Im 27		Margaret Jewell 1  20a. Method of Disposition	Nehrenz (v					Ville, Mar	yland 21234
201	ages nt of h t: # lte		1 TBurial 2 ☐ Cremation 3 ☐						,	
Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 eny injury or other once.		4 ☐Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		Moreland				Baltimore,	
B	Depa Impo eny i		George J	Ferras	n I	6500 Yor	Wiedefeld k Road B	funeral altimore	Home, Inc., Maryland	1 21212
87			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death. Do not ent ine.	er the mode of dyir	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	achte	rin	el fou	lune		
	Examiner			Due to (or as	a consequence of):	1.1				1
and the second	i d	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):			1		
22	ecuted and I-transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	18 636	relun	u d	r Sea	16	
68760,	cien cien	E E	resulting in death) Last	Due to (or as	a consequence of					
587	ificate b g physical as the b	Medical	*>	d						
Box (		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		ne			23d. Date of del	ivery
	death	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant a		]Ectopic pregnanc ] Other (specify) _	у		Month	Day Year
P.0	that the de ed by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions		out not consisting in the su		una in Rant I	230 Did tob	acco use contribute to	the cause of death?
Vital Records,	Se Co	d by	Part II. Other significant conditions	contributing to death t	out not resulting in the u	nderlying cause giv	venin Parti.			obably 4 Durknown
000	aw requir s been si 2 should I	Completed						24a. Was an		itopsy findings available
R		mo						autopsy perform 1 Yes 2	led? death?	completion of cause of
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medicat examiner?				26. Place of Deatl		)	
of	Phys this al dii	- To	1 Yes 2 No	Hospital: 1 Inpati 28a. Date of Inj		I 3 DOA		me 5 Resider	nce 6 Other (Spe	cify)
on	ding F th. After tuner	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	Year) Injury	Wo	rk? ]Yes 2 \Bo	20d. Describe no	w injuly occurred	
Division	l or Attend after death Director: A	ifica	3 Suicide 6 Could not to	28e. Place of In	jury - At home, farm, str			28f. Location (Str. City or Town,	eet and Number or Ru	ıral Route Number,
Ö	Hospital or A 24 hours after Funeral Directely filled in by	Certification:			tc. (Specify)					
	To the Hospital or within 24 hours after To the Funeral Directorpletely filled in b	edical	29a. Certifier (Check only one)  Certifying P  Certifying P  Certifying P	nysicien: To the best miner: On the basis of and manner s	of my knowledge, death of examination and/or in lated.	h occurred at the tri vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2	0 =	29c. Licens	se number	29	d. Date sig ed (Mont	h, Day, Year)
			) to	risu		MM	11/5/15	72 9	1006	
	ip		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)	other.	BluA	Dark & D.	Widon 24
100	is as a	•	31. Date filed (Month, Day, Year)	- Regist	rar's Signature	8000	21-21	() (U)	Lockath	Com Men
	Sta Registr	4.75	SFP 2 2 20		J. 1900	Marie Committee of the				į,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17.18 per fb e860 10-5-06 vt. State of Maryland / Department of Health and Mental Hygiene Rag. No. 2006 1 - For State Registrar Certificate of Death 2. Date of Death dent's Name (First, Midd 3. Time of Death Last) Day **Physician** 19, 2006 September OWN 05.39 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Samari tan Hospital Baltimore 7. Age (In yrs. last birthday). If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Day, 6. Sex 9. Birthplace (State or Foreign 31-01-5826 10 M 2□F Months Days Hours Min. Nors IJsual Residence of Decedent Oa State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 **2** es 2 □ No Completed by Funeral Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ISA 0116 Was Decedent Ever in U.S. Armed Forces?

1. ☑ Yes 2 ☐ No

1. ☑ No

1. ☑ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 10 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) S Name (First, Middle, Last) 17. Father's 18 Mother's Name (First, Middle, Maiden Surname, Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oseph Mc Crae SON 2319 (16)
20b. Place of Disposition (Name of cemetery, crematory or other parts) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee Name and Addre Corredge Fr k Zoad, Mac cardiac or respiratory arrest, ork 23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each Jne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 🔲 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Tes Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) No 2 ER/Outpatient 1 🗌 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

use as the burial-transit been signed by the a should be detached f certificate this After thi death. the Funeral Director: / within 24 hours a To the Hospital

**Funeral** 

Director

or 28a-f show

or Items 23a

"natural",

other traumatic event, the Medical Examiner must be notified at

with the Maryland

death

filed within

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 Is marked other than '

permit. Pages 1 Department of H Important: If Ite any injury or otl ance.

**Physician** 

Baltimore, Maryland 21215-0036

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 25a) (Type-Print)

MN 5001 COCH Raven Julie 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

SEP 2 2 2006



Cooke

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c, License number

29d. Date signed (Month, Day, Year)

			1 - State of Marylan		artment of H			ene g. No. 200	6 30142	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  JACOB DAVID		NAGEL		2. Date of Death Month SEPT.	1 <sup>0</sup> 3 <sup>y</sup> , 2006°	3. Time of Death 4:00 P M	
1	Examir		4a. Facility Name (If not institution, give street and number) 16314 FALLS ROAD		4b. City, Town, or	BUTLER			ALTIMORE	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1) M 2 F 66		If Under 1 Year Months Days	If Under 24 Hours Min		1940 9. Bi	rthplace (State or Foreign ountry) MD	
	e Maryland ta-f ehow	ctor	La contraction of the contractio	ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🎇 No	
	eth with the 23s or 28	Funeral Director	10e. Street and Number 16314 FALLS ROAD		10f. Zip Code	21023		10g. Citizen of What Country?		
920	et', or Item	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U Armed Forces?  1 Yes, 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? In, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Whi		
Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland lat Hygiene. Id other then "naturet", or iteme 23a or 28a-f show other then "naturet", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+	(Give	dent's Usual Occupa kind of work done a DO NOT use retired, SICIAN	ition luring most of w	orking 1	6b. Kind of Business	:/Industry	
land 2	S E D	To Be C	17. Father's Name (First, Middle, Last) HENRY	NAG		18. Mother's N	ame (First, Middle, M		WINKLER	
	nd 2 st lith ar 27 is r trau		19a. Informant's Name/Relationship (Type, Print) DIANNE NAGEL / WIFE	163	14 FALLS		BUTLER, MD	21023		
Baltimore,	Pages entol nt: If i		1 (X Burial 2 □ Cremation 3 □ Removal from State BAL	TIMORE	sition (Name of matory or other place HEBREW C	EM. 09/	21/2006	Oc. Location - City of REISTERS	TOWN, MD	
■ Bal	permit. Depertm Importa. eny inju		21. Signatural Funeral Service Licensee  Jay Leus  23a. Party. Enter the disease, or complications that caused the deat		MD 21208					
18760,	death certificate be executed //Medical Examine e ettending physicien and for use as the burial-transit	dicai Examiner	snock, or near failure. List only one cause on each line.	uence of):			SCLER		Interval 8etween Onset and Death  Grant AR  Onset AR  On	
O. Box 6	at the death certific by the ettending p	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year	
σ.	signed d be de	by P	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	1.	o the cause of death?	
of Vital Records,	The law ate has b page 2 s	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
Division of Vit	spitel or Attending Physicien: Tours after death. Teral Director: After this certificat filled in by the funeral director, pr	Certification; To Be	27. Manner of Death  1	ER/Outpatien 28b. Time of Injury	28c. Injury Work M 1   Y	r: 4 Nursing	Home 5 Residen 28d. Describe hov	ce 6 ☐Other (Spe		
Ö	Hospitel or 1 24 hours after Funeral Dire		29a. Certifier Certifying Physicien: To the best of my kno	y)	occurred at the time	e, date and place	City or Town,	State)	s stated	
	To the Hos within 24 h To the Fun completely	Medical	(Check only one)  2 Medical Exeminer: On the basis of examina and manner stated.  29b. Signature and title of certifier	tion and/or inv	29c. License	number	290	e and place, and due	th, Day, Year)	
7	0		30. Name and address of person who completed cause of death (Item	23a) (Type,		1866	,	7/20/	2006	
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 2. 2 2006 32. Registrar's Signa	(turk	coste					

DHMH 17 Rev 1/2001

6-06989			Please Type or					
Cenneth William		- For State	of Maryland / Depart	rtment of H Hificate of D			Reg No. 200	16 3014
Physicia		Registrar 1. Decedent's Name (First, Middle,Las	st)			2. Date of De	ath	3. Time of Death
Medical Exami	ner	Kenneth W.	O'Donnell			Month Septemb	Day Year er 16, 2006	0305 hrs
		4a. Facility Name (if not institution, giv Upper Chesapeake Medic			City, Town, or Location Bel Air	on of Death	4c. County of Deat Harford	h
Funeral		5, Social Security Number 6. S	ex 7. Age (In yrs. la	- '' L			Forei	rthplace (State or
Director	1		M 2 F	41 Yrs	Months Days Ho	urs Min. 4/14		puntry) MD
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d Inside City Limits
* o*	_	MD Harfor	d H	avre De	e Grace			1 Yes 2XXNo
vlaryland 28a-f show d at once.	Director	10e Street and Number		11	Of, Zip Code	_	10g. Citizen of What Cou	intry?
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland art of Heatht and Mental Hygiene.  unt: If item 27 is marked other than "natural", or items 23a or 28a-f show re other traumatic event, the Medical Examiner must be notified at once.	ä	667 Green St.			21078		USA	
ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?			Origin? (Specify Yes or Norman, Puerto Rican, etc.)	o- 14. Race - Amer White, etc.	ican Indian, Black,
death or ite	μ̈́	1 Never Married 2xxMarried	1 Yes 2XX No					. L _
s after ral",	<u>S</u>	Widowed 4 Divorced  Divorced  Divorced  Divorced  Specify of	If Yes, Give Year or Dates:		es <b>XX</b> No s <i>pec</i> Usual Occupation (Gi		Specify: Wh	
! hours aft "natural" Exaguine	te d	Elementary/Secondary (0-12)	College (1-4 or 5+)		of working life. DO No		Tob. Kind of Business/	il idusti y
5-0036 ted within 72 Tygiene other than '	Completed	12	, , , , , , , , , , , , , , , , , , ,	Lal	borer		wareho	use
21215-0036 suld be filed within 7 Mental Hygiene marked other than e event, the Medica	डि	17. Father's Name (First, Middle, Last			18 Mot	her's Name (First, Middle,	Maiden Surname)	
2121! hould be fill nd Mental F is marked tic event, I	a	Francis O'Do				Alberta Kl		
D 21215-003 should be filed with and Mental Hygiene 7 is marked other thatic event, the Mec	2	19a. Informant's Name/Relationship (		1		Number or Rural Route Nuill Ave. D		
Tore, MD 2 ages 1 and 2 shoul nt of Health and N tt. If item 27 is n other traumatic	ŀ	Charmane L. ( 20a. Method of Disposition	D'Donnell		n (Name of cemetery,	Date	20c. Location - City of	
Ore ges 1 g t of H t of H			Removal from State Eva	rematory or other ns Fun	eral	Sept.	Porost	U:11 MD
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	- 14	4 Dopation 5 Other Specify 21. Son up of Funeral Septime Lice		pel- B	el Air se and Address of Fac		Forest	
Balti permit. Departm Importe		Mar 10-15	7/	Eva	ns Funer. Bel Air	al Chapel-	Forest_Hi	rt Dr. 11, MD2105
Physician		3a. art I. Enter the disease, or com						Approximate Interval Between Onset and
/Medical		failure. List only one cause on e Immediate Cause (Final disease a	Multiple Injuries					Death
T,xaminer	- 1	or condition resulting in death)	Due to (or as a consequence of	).				
	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	١٠				+
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated		,.				
14. B E	Xar	events resulting in death) Last	Due to (or as a consequence of	):				
y xecuted	= 1	C LINDENDED				<u>-</u>		
760, icate be exect physician at the burial - 1	ledi	UNPENDED	AMENDED  23c. If yes, outcome of pregr				23d. Date of deliver	
876 tificate ing phy as the l	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	1 Live birth		death 3 Ect	opic pregnancy		Day Year
, P.O. Box 687 res that the death certifi signed by the attending be detached for use as 1	sici	1 Yes 2 No 9 Unknow	4 Pregnant at time of dea	ath 5 Other	(Specify)			
the de	P	Part II. Other significant conditions	9 OIKIOWII	sulting in the und	erlying cause given in	Part I 23e Did	tobacco use contribute to	the cause of death?
, P.O. res that the signed by be detach	ģ	Turin Guior organicani Gonzalia	continuating to dodn't but not re	outing in the una	strying dada given i		es 2 V No 3 Pro	bably 4 Unknown
ds, equire een sig	Completed				<del></del>		s an 24b. Were a	utopsy findings available
cords law requi has been	aldu						ormed? death?	completion of cause of
Re : The fficate f, page	ဒ	25. Was case referred to medical	<del></del> -		26 Place of Dec	1 ✓ Yes ath (Check only one)	2 No 1 Y	es 2 No
ital sician s cert	Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other		Residence 6 Othe	
Division of Vital Records, P.O. Box 68760, rat or Attending Physiciau: The law requires that the death certificate be as flee death. The rather death are certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur	. To	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	28b. Time of Inju		/ork? 28d Describe	how injury occurred	
Sion C trending death ctor: Af	tion	1 Natural 5 Pending	Sep 16, 2006	0103 hrs	1 Yes 2	✓ No Passenger	auto auto collision	
ViSit or Atte ter des virecto n by ti	fica	2 ✓ Accident Investiga 3 Suicide 6 Could no	28e Place of Injury - At ho	me, farm, street,	factory, office building	g, etc 28f. Location	(Street and Number or R	ural Route Number, City
Div pital o surs af eral D	Certification:	4 Homicide determine		et		Rt. 7 / Bris	tol Forrest Rd. , Be	llcamp, MD
Division of Vital Records, P.O. Box 68760, "To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		(Check only	cian: To the best of my knowledg					
To th within To the	Medical	2 🔻	er:On the basis of examination ar and manner stated	id/or investigation	29c License numl		29d Date signed (Mo	
	2	29b. Signature and title of certifier			250 Licerise numi	DC:	230 Date Signed (IVI)	Juur, Day, (edi)

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) ORIGINAL O.C.M.E.

September 16, 2006

State

Registrar

			1_ For	State of Maryland /			ygiene 2006	3011.1.
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Dea	2. Date of D	neg. No.	
u	Physici		FILA	$\triangleright$	90000	Month	Pax 2006	3. Time of Death 3. WA M
	/Medio		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Locati	on of Death	4c. County of Deat	<u> </u>
			Madonna He	ritage	-arrests v	ille	Harto	10
	Funeral Director		5. Social Security Number 6. Sex	M 20 F 7 Age (In yrs, last bi	rthday) If Under 1 Year If Uni Yrs. Months Days Hou	rs Min. 8. Date of B	Birth 9. Birth Day, Year) 9. Birth	nplace (State or Foreign untry) NESSE
			Usual Residence of Decedent	110.01.7		4/2	1/10/10/	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tial Hygiene.  di other than "natural", or items 23a or 28a-f show event, the Medical Exercical most be notified at	f shov	ō	10a. State 10b. County	10c. City, Tow	Forcest 11	11		10d. Inside City Limits 1 ☐ Yes 2 No
the A	7 28a-	Funeral Director	10e. Street and Number	)/A	10/23 H1		10g. Citizen of What Co	
th witi	23a o	a D	518 W. Jarrettsvil	le Rd. P.O. Box T	144 2105	7	115+	
	Hems German	une		Was Decedent Ever in U.S.     Armed Forces?	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or Nican, Puerto Rican, etc.)	No- 14. Race - Amer Black, White	
1215-0036 within 72 hours after	Execution 1	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 🔏 No Spec	cify:	Specify:	hite
<b>21215-0036</b> d within 72 hours af	natur	Completed	15. Decedent's Educ (Specify only highest grade		. Decedent's Usual Occupation (Give kind of work done during n	nost of working	16b. Kind of Business/I	ndustry
<b>121</b>	then.	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	iffe. DO NOT use retired)	, and the second	at ha	m o
N D	other ent.	Be Co	17. Father's Name (First, Middle, Last)			other's Name (First, Midd		
arylan should be	920	ToB	Jess Chard	ler	T	annie 1	Dowers	
10	7 is mar		19a. Informant's Name/Relationship (Type		b. Mailing Address (Street and Nui	mber or Rural Soute Num	. 2 71111	al Il ill ach
	f Health Item 27 other tr		20a Method of Disposition	- 50 M 5	f Disposition (Name of	Ville No. V.C		rest Hilling
Pages	으= = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State EvanS 11	ny, crematory or other place)		Front H	11 MD
Baltimore,	Depertment important: eny injury conce.		21. Signatur of Funeral Service License		ULTA CHARLE-BE 22. Name and Address of Fa	cilling Newport	-DR. Forest	Hill
TI 8	0.5 2 3		Expuberly U	Liolay	EVANS FUNER	MICHAPEL	-BELAIR N	10 31030
Die			23a. Part . Enter the disease, or combine shock, or heart failure. List only on Immediate Cause (Final	1/1/2	2	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	ysician /ledical		disease or condition resulting in death)	PRTERIO S  Due to (or as a consequence				
Ex	aminer		Sequentially list conditions, b.	OSTEO	ARTHRITIS			
10 B	1sit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ON): STIVE HEA	DT FALL		
7.2.5 0.0.5	icien and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a consequence		/-/   AIC	LIURE	
cate be execui	ohysicien the buria	dical	<b>€</b> d.					
X 65	ding pl	lan/Med	IF FEMALE:	3c. If yes, outcome of pregnancy				
BOX Seath cert	ettend for us	clan	in the past 12 months?	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliving Month	very Day Year
F. O. at the	by the tachec	Physici	1 ☐ Yes 21 No 9 ☐ Unknown	9□ Unknown				
_	been signed by the ettending p should be detached for use as	Completed by P	Part II. Other significant conditions conf	tributing to death but not resulting i	n the underlying cause given in Pa		tobacco use contribute to	
<b>Kecords,</b> he law requires t	been s should						-	bably 4 Unknown
r g	has 9e 2					24a. Wa auto peri	opsy prior to co	opsy findings available ompletion of cause of
	certificete rector, pag	0	25. Was case referred to medical		26.19	1 ☐ Yes		2□ No
		To B	10105 201140	ospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA Other: 4		sidence 6 Other (Speci	rfy)
on o	After t funera	tlon:	27. Manner of Death 1 Natural 5 Pending		Time of njury at Work?  M 1 ☐ Yes 2		how injury occurred	
DIVISION I or Attending	ctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa		28f. Location	(Street and Number or Rui	ral Route Number,
Tel o	at Dir	Cert	4   Homicide	building, etc. (Specify)		City or To	own, State)	
Hosp	within 24 nours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) 1 Certifying Physical Examin	ician: To the best of my knowledge er: On the basis of examination an and manner stated.	e, death occurred at the time, date down investigation, in my opinion, o	and place, and due to the death occurred at the time	e cause(s) and manner as :	stated. to the cause(s)
o the	o the	Med	29b. Signature and title of certifier	and manner stated.	29c. License numbe	er	29d. Date signed (Month,	Day, Year)
_	, - 0		*//www	Zuro.	10450	121	SEPTEMBER	19 2006
	2		30. Name and address of person who cor	npleted cause of death (Item 23a)	29c. License numbro D456 (Type, Print) OLD EMMOR7	0 -	MARYLAM	10 21015
	۲ ۵۱		31. Date filed (Month, Day, Year)	32. Resistrar's Signature.	OLD EMMORT	TON KD. S.	VITE 212	BEL AIR
	Sta Registr		SFP 2. 2. 70	106 Magnes St	figsel.			

			1 - For Amend item Registrar	#8,perFH,	99, Maryla	nd Depa	artment of I rtificate of	Health and I <i>Death</i>	Mental Hy	rgiene 200	16 30145
	Physic	an	Decedent's Name (First, Mide						2. Date of De Month		3. Time of Death
	/Medi	cal	Charlie Milton  4a. Facility Name (If not instituti		<u> </u>		45 City Taylor			1	006 12:35 AM M
	Examir	ner	Gilchrist Cent			are	Tows	or Location of Deat SON	n	4c. County of Dalt:	imore
45	Funeral Director		5. Social Security Number 219-32-2963	6. Sex 1 M 2 ☐ F	7. Age (In yrs 68	s. la <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days		8. Date of Bir Month, Da 12/10/	rth 1938 9. 1937 MD	Birthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. C	ity, Town or Lo	ecation				10d. Inside City Limits
	Maryl ind a	ţō	MD Balt	imore		ynn Oak					1 ☐ Yes 2 No
	th the	Director	10e. Street and Number				10f. Zip Code	<u> </u>		10g. Citizen of Wha	t Country?
	s 23a		7016 Windsor M				21207			United St	
920	72 hours after death with the Maryland nature!', or tems 23a or 28a-f show lissel Exeminer must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☒ Divorce	Armed I	2 No Sive	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🗖 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		American Indian, Vhite, etc. hite
Maryland 21215-0036		Completed		ent's Education est grade completed	(1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Cutter	during most of wor	king	16b. Kind of Busin Grocery	ess/Industry
land 2	should be filed within nd Mental Hygiene. I marked other than 'umatic event, the Me	To Be Co	17. Father's Name (First, Middle Milton George		-				ne (First, Middle Caylor	, Maiden Sumame)	
, Mary	and 2 should salth and Men n 27 is marke er traumatic		19a. Informant's Name/Relation Terry T Phillip					and Number or Ru ad Catons		er, City or Town, Sta MD 21228	te, Zip Code)
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		n State	cemetery, cren	sition (Name of natory or other pla ce Cremat		Sep 23 2006	20c. Location - City Beltsville	or Town, State
Ball	permit. Pag Depertment important: I any injury o once.		21. Signature of Funeral Service	Ritta	M0144	(3 8	717 Green		Drive B	Baltimore,	Maryland
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	each line.	catro	er the mode of dyir	ng, such as cardiac			Approximate Interval Between Onset and Death
68760,	tificate be executed g physicien and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b>	o (or as a conse						
P.O. Box 68	To the Hospital or Attanding Physicien: The law requires thet the death certificat within 24 hours after death. with R Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregr birth 2 Fet pnant at time of nown	aldeath 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
rds, P	quires thet an signed b uld be deta	by	Part II. Other significant condit	ions contributing to	death but not re	sulting in the ur	nderlying cause giv	ren in Part I.	23e. Did to	\	e to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	: The law requir cete hes been si page 2 should l	Completed							24a. Was autor perfo 1 Yes	osy prior deatl	e autopsy findings available to completion of cause of 17
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Cth	26. Place of Dea			
ion of	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	atlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date		28b. Time of Injury	28c. Injur Wor	y at		dence 6 Cother (S	ipecity) NOSPÎQ
Divis	tal or Atts rs after des st Directo ed in by th	Certification;	3 Suicide 6 Could 4 Homicide deter	mined 286. Place	e of Injury - At h	nome, farm, stre	eet, factory, office		28f. Location (S City or Tov	Street and Number or wn, State)	Rural Route Number,
	the Hospi in 24 hour ths Funer ipletely fills	edicai	one) 2 medica	and ma	e best of my knobasis of examination	owledge, death ation and/or inv	estigation, in my o	pinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	To To	Σ	29b. Signature and title of certific	eranla	/ w~		29c. Licens	e number		29d. Date signed (M	
,	10		30. Name and address of person	who completed cau	ise of death (Ite	m 23a) (Type, F	Print)	10303			21 2006
	Sta	te_	31. Date filed (Month, Day, Year	7) 32	Registrar's Sign	ature	when It	Stim	ne ur	2(204	
3,	Registr		SEP 22	2006	Come de	K Apa	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician WITTIL 4a. Facility Name (If not institution, give street and number) 20 /Medical 200 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimase 10 06/X Ox1 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 60-5846 Days Months Hours Min Director Usual Residence of Decedent with the Maryland 10a. State r 28a-f ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore md. 1 ☐ Yes 2 No Director Windso 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Apt, permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or in injury or other treumatic event, the Madical Examinet must be note. # Funeral Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 200 facil þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimoil Elementary/Secondary (0-12) College (1-4or 5+) Gas Electri 2+1 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sho Shone ct. 9914 Antoinette Colom 21133 Kandallstown Vernn 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9-28-06 4 □ Donation 5 □ Other (Specify) Valla men 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of negritalities. List only one cause on each line.

Immediate Causelfinal disease or condition resulting in death)

a. http://www.final.com/final. 21. Signature of Funeral Service icensee Dalto, nd, 21209 Approximate Interval Between Onset and Death **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2. NO 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Ceath 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death. 1 Yes 2 No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Dale filed (Month, Day, Year)

2006

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2006 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** HENRY E. PEAR SEPTEMBER 20 Z:10 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner +COSPITAL TZZW HTJOON RANDALLSTOWN BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Days 5, Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 □ F 0870871916 Yrs. 213-05-7427 90 MD Director Usual Residence of Decedent the Maryland 10a State or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 ☐ Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4204 OLD MILFORD MILL ROAD 21208 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S.
Amped Forces?
1 A Yes 2 No COAST
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced Year or Dates: GUARD To Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) uring most of working College (1-4or 5+) 5+ Elementary/Secondary (0-12) C.P.A. ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **PEAR** LOUIS FLORA BILLIG ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3420 LUDGATE ROAD - BALTIMORE, MD 21215 BARRY PEAR / SON Item 2 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If Its eny Injury or ot once. BALTIMORE HEBREW CEM. 9/21/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA ASPIRATION Securities list continued in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed physicien and the burial-transit Exam resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death P.O. I 5 Other (specify) 9□ Unknown 9 Unknown sete has been signed I page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes : After this certifice funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Enpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Descertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 SEPTEMBER 2006 MITTERA TODOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSPITAL SHOL OLD COURT ROAD RANDALLITOWN MD 21133 NORTH WEST 32. egistrar's Signatule 31. Date filed (Month, Day, Year) State Registrar

			1 - For Stete Registrar	State of Ma	ıryland		artment o			ind Mer		<sup>епе</sup> 2 0	06	30148
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, La  GEORGE John 4a. Facility Name (If not institution, give  A Medical Hea	e street and number)	YNSK Center		4b. City, To		ocation of	5 f Death	Date of Death Month eptembe	Day	Year LCO6 of Death	3. Time of Death
	Funeral Director		5. Social Security Number 213-34-9560 6. S		(In yrs. las	t birthday) Yrs.	If Under 1 \	Year	If Under 2 Hours	4"Hrs. A	Date of Birth	1 <b>°9</b> 37	9. Birtho Mary 1	lace (State or Foreign and
	e Maryland 3a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, T	Town or Lo							1	0d. Inside City Limits 1 X Yes 2 □ No
	with the	Dire	10e. Street and Number 5712 Greenhill Av	enile			10f. Zip Co					g. Citizen of V	Vhat Cour	itry?
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23e or 28e-f show injury or other traumatic event, its Madical Evanti at mast be retilified at injury or other traumatic.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent E Armed Forces? 1 Wes 2 N If Yes, Give Year or Dates:	ver in U.S.		Was Deceden	t of Hisp Cuban,	panic Orig Mexican, Specify:	in? (Specify Puerto Rica		14. Race Blac	e - Americ k, White,	etc.
21215-0036	ithin 72 ho ie. ien *natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5-		(Give life.	dent's Usual ( kind of work ( DO NOT use i	done du	on ring most	of working		6b. Kind of Bu		
nd 21	se filed withln al Hygiene. I other than ' ivent, I's Ma	Be Con	10th grade  17. Father's Name (First, Middle, Last,			Mach	ninist	1	8. Mother	r's Name (Fi		Enginee		Company
Maryland	2 should be and Mental is marked c	To Be	Walter Ptaszynski  19a. Informant's Name/Relationship (			19h Maili	an Address (S	treet an	Agne		uta Numbar	City or Town,	State 7in	Codel
, Ma	and 2 s salth an n 27 is:		Victoria Young, d				Emory				erco,			0000)
Baltimore,	Pages 1 and 3 nent of Health int: if item 27 iry or other tra		20a. Method of Disposition 1 ☐ Burial 2 ②Acremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)		cem	letery, crei	osition (Name matory or othe ematory	r place)		Date ept 22	2, 2006	Oc. Location - Balt		
Balti	permit. Page Department Important: fl any injury o		21. Signature of Juner Service Licer	isee		22	2. Name and A	Address	of Facility	Miller	-Dippe	l Funer	cal H	ome, Inc. d 21206
8760,	/Medical be executed // /Medical unding physician and phys	lical Examiner	23a. Part1. Enter the disease, or com shock) or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c. Due to (or as a d.	consequer	nce of):	er the mode o				spiratory arre	st,		Approximate Interval Between Onset and Death 2 5 YEARS
.O. Box 6	death certif e attending ad for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3[	Ectopic pregi					23d. Date Mor	e of delive	ry Day Year
٥.	es lgn be		Part II. Other significant conditions of Coronary Arts	ontributing to death bu		ng in the u	nderlying caus	se given	in Part I.		23e. Did toba			e cause of death?
Vital Records,	The law ate has b page 2 sl	Completed by	Diabetes M	ellitus							24a. Was an autopsy perform 1 Yes 2	ed? d	rior to cor leath?	osy findings available inpletion of cause of
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatier	* 2055	2/Outpation	nt 3□ DOA	Other:			heck only one	ce 6 □Othe		a a
on of	Jing After fune		27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28	Bb. Time of Injury		Injury a Work?		28d.		v injury occurre		7
Division	F 9 F -	Certification:	3 Suicide 6 Could not b determined		ry - At home . (Specify)	e, farm, str	reet, factory, o	ffice		28f.	Location (Stre City or Town,	et and Numbe State)	er or Rura	Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  Certifying Ph	ysician: To the best on niner: On the basis of and manner state.	examination	edge, death n and/or in	h occurred at t vestigation, in	the time, my opin	, date and nion, death	i place, and h occurred a	due to the cau t the time, dat	use(s) and mai e and place, a	nner as st and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier		m.e.	dica	0 1	icense n			0	d. Date signed		•
	6		A duenne 30. Name and address of person who	Completed cause of de	path (Item 2:	Liclen 3a) (Type,	Print)	17	40	1	1 2	Septen	ber	20,2006
	V	200	ADRIENNE FLOW	ERS. 22	Sou-	th G	reery	Str.	eet,	Bal	timore	mb,	21	201
	Sta Registr		SED 9 2 2006	32. Hegistra	-	Sou								

DHMH 17 Rev 1/2001

Jamie W. Kandall

Please Type or Print in Black Indelible Ink

**UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2006 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Month Day Y September 18, 2006 Medical Examiner 1805 hrs MICHELLE RANDALL JAMIE 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2300 block West Lanvale Avenue **Baltimore** NA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Foreian Hours Director M 2 4 F Country) 220.92.1263 30 1971 08.27. MD Usual Residence of Decedent Ä 10c. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show must be notified at once. BALTIMORE Yes 2 K No MD GWYNINI OAK death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country FOREST PARK AVENUE 21207 1407 U.SA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes Yes, Give Year Widowed Divorced Yes 2 No specify: Specify: BLACK 'natural". ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Flementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 l nen of Health and Mental Hygiene ant: If iten 27 is marked other than "t or other traumatic event, the Medical E Baltimore, MD 21215-0036 12/14 GRADE COOK NURSING HOME 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be MICHAEL RANDAU DARLENE Young ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Young MOTHER DARLENE 1407 FOREST PARK AVE. BAUTO. MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State crematory or other place) 1 & Burial 2 Cremation 3 Removal from State permit Pages
Department of
Important: I 09.26.04 MOODLAWN BALTIMORE MD Donation 5 Other Specify Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUTO, NATI PIKE, BAUTO, MD 21229 m 23a. Par Center the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical a. Multiple gunshot wounds of head and torso Death Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED ending physician use as the burial requires that the death certificate be P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Day Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? Yes 2 ✓ Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Inpatient DOA Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot FOUND Natural 5 Pending 1 Yes 2 V No Sep 18, 2006 1755 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2300 block West Lanvale Avenue, Baltimore, M (Specify) Local Street 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME September 19, 2006 30 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical\_Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mosth-Day Year) 2006 32 Registrar's Signa State

Registrar

		•	1 - For State Registrar		•	ertificate of			Reg. No.		30130
			1. Decedent's Name (First, Middle, La	•				2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic	2	Catherine Elizabe	th Sendldo	rfer			Septem			9:00 A M
<b>)</b>	Examin		4a. Facility Name (If not institution, giv				or Location of Death			unty of Death	
			Riverview Care Ce 5. Social Security Number 6.5		e (In yrs. last birthda		SeX If Under 24 Hrs.	9 Date of Rid	1	Baltimo	
	Funeral Director				5 Yrs	Months Days	Hours Min.	8. Date of Bir (Month, Da Dec . 29	, 1920	Mary	place (State or Foreign ntry) Land
	land ow		10a. State 10b. County		10c. City, Town or	Location				1	IOd. Inside City Limits
	Man,	tor	Maryland Baltimo	re	Ess	ex					1 ☐ Yes 2 📉 No
	th the	Director	10e. Street and Number	_		10f. Zip Code			-	of Whal Cour	ntry?
	ath w 23s	rai	922 Thompson Blv			21221			USZ		
2-0036	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. do ther then "neturel", or iteme 23a or 28e-f ehow event, the Medical Exacilitat prints for political at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent   Armed Forces?   1 Yes 2 2 1   If Yes, Give Year or Dates:	Ever in U.S.	3. Was Decedent of h If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No o Rican, etc.)	1	Race - Americ Black, White, ecify: Whit	etc.
ດ່	72 h	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. De (G	cedent's Usual Occup ve kind of work done . DO NOT use retire	during most of work	king	16b. Kind o	of Business/In	dustry
121	within 72 ene. then "net	Completed	Elementary/Secondary (0-12)	College (1-4or 5		. DO NOT use retire OUSEWI FE	d)		Own	Home	
2	filed v Hygie other t		17. Father's Name (First, Middle, Last	)			18. Mother's Nam	ne (First, Middle,			
		To Be	Unk.		heider		Theresa				
ary	s 1 end 2 should be t Health and Menta frem 27 ie marked other traumatic ev	_	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Address (Street	and Number or Rui	ral Route Numbe	er, City or To	own, State, Zip	Code)
Σ	end 2 salth a n 27 le		Theresa M. West (	Daughter)		Thompson		ltimore	, Mary	land 2	1221
ore	of He of He fiten		20a. Method of Disposition  1 Surial 2 Cremation 3	Removal from State	20b. Place of Dis cemetery, of	position (Name of rematory or other pla		Date	20c. Locati	ion - City or To	own, State
Ĕ	Pag ment tent: jury o		4 □ Donation 5 □ Other (Specia	y)	Oak Law	n Cemetery	1			more, M	Maryland
Baltimore,	permit. Pages 1 en Department of Heali importent: If item 2 any injury or other once.	2	21. S mature of Fundral Service	In oh	· C ·	22. Name and Addre Bruzdzins 1407 Old 1	ss of Facility Ki Funera Eastern A	l Home l venue Es	P.A. ssex,	Maryla	nd 21221
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lir	the death: Do not	enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
7	hysician		Immediate Cause (Final disease or condition	a. My	perter	dian					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):	N. 11	1				
		-	Sequentially list conditions,	b. Due to for as	a consequence of .	الغار,	au		_		
	nted Insit	mine	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury	12	nerh	leden					
<u> </u>	execun and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):	1	du na:				
68760,	tificate be executed g physicien and as the burial-transit	edicai		d. A13	heime	n der	nenta	0			
			IF FEMALE:	23c. If yes, outcome	of pregnancy					D-1	
P.O. Box	The law requires that the death centil attending ate has been signed by the attending page 2 should be datached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 (∑No 9 ☐ Unknown		2 Fetal death	B Ectopic pregnanc	у		23d.	. Date of delive Month	ory Day Year
ر. ح	s that ned b e data	y P	Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use o	contribute to th	ne cause of death?
ğ	quire an sig	ed b						101	res 200	lo 3 🗆 Prob	oably 4 Unknown
Vital Records,	e law re has bee	Completed						24a. Was	an 24	4b. Were auto	psy findings available mpletion of cause of
<u> </u>	hysician: The is his certificate has I director, page 2	Con						perfo	rmed?	death? 1 ☐ Yes	
<u> </u>	ician certifii ector	Be	25. Was case referred to medical examiner?	Hospital:		O++	26. Place of Deal				
	Phys r this ral dii	5	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 inpatie		BILL 3 DOA	4 K I Murshing He	ome 5 ☐ Resident			y)
O	Attending Physician: r death. ector: After this certific: by the funeral director.	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injui (Month, Day	Year) Injur	Wo	rk?  Yes 2 □No				
_	- 0	ertification:	3 Suicide 6 Could not be determined		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Ni vn, State)	umber or Rura	d Route Number,
	To the Hospitet or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Ph	nysician: To the best on the basis of and manner sta	examination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the rred at the time,	cause(s) and date and pla	d manner as si	tated. o the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certifier			29c. Licens				igned (Month,	
			1 / 2 lock	7		D	00551	7-1	91	20/06	
	W		30. Name and address of person who Sebastian 7	completed cause of d	eath (Item 23a) (Type 3 Coufe	e, Print) Aren	ne Bot	thmore	MO	ر کی	224.
b	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 2			Speciel					

State of Maryland /	Department of He	ealth and Mental	Hygiene 2	006	301	5

Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 7.00 PM SEPT 18 2006 James Wilmer Swain /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital BALTIMORE St. Agnes | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 15€M 2□F Yrs Director 216-12-0584 Jan.25, 1922 Maryland 84 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore Catonsville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death via Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23-any injury or other traumatic event. The sec 21228 408 Lambeth Road USA Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Central Office Technician C & P Telephone Comp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruth Hummer LeRov E. Swain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Lambeth Road; Catonsville, MD 21228 Elaine Swain Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cem. 9/22/2006 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Sterling Ashton\_Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EDEMA Physician 2 Days /Medical Due to (or as a consequence of): Examiner SEVERE STENOSIS YEARS AORTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Physician: The law requires that the death certificate be executed noumoma Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) the 9 Unknown cate has been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: the Hospital or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified M.D. P18612 SEPT. 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Agnes 900 S. Caton Avenue, POBOX 198, BALTIMORE, MD, 21229 Hos pital 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Goarde Registrar 2006

DHMH 17 Rev 1/2001

JAMES

06-07096 Marid Garcia

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 30152

		1- For State Registrar			Ce	ertifica	te of Dea	th			Reg. No.	-00	0 0010
Physici	an/	1. Decedent's Name (Fi	rst, Middle,La	st)						Date of De    Month		ear	3. Time of Death
edical Exami	ner				O GARC	IA S				Septemb	er 19, 2006		2245 hrs
		4a Facility Name (if not Route 140, eas			umber)			, Town, or t stminste	Location of De <b>r</b>	eath	4c. Count	ty of Death	
Funeral		5. Social Security Numb			7 Age (In yrs	last birtho		ider 1 Year		Hrs. 8. Date of E			tholace (State or
Director		UNKNOWN		M 2 F			Mon			vlin.		Foreig	ın
		Usual Residence of De		F		21	Yrs			4/1/	1985		untry) MEXICO
any			County		10c. Cit	y, Town or	Location						10d Inside City Limits
≱	Ļ	MD	CARRO	LL		WEST	MINST	ER					1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number						ip Code			10g Citizen of \	What Cour	ntry?
vith the Maryland s 23a or 28a-f show e notified at once.	ä	5 WARD	AVE					211.	57		MEXI	CO	
with ns 23. be no	<u>ra</u>	11. Marital Status			cedent Ever in	U.S.				Specify Yes or N	lo- 14 Ra	ce - Ameri	can Indian, Black,
death r iter nust	Funeral	1 X Never Married	2 Marrie	d Armed F	orces?					erto Rican, etc.)		nite, etc	
after al", o	by F	3 Widowed		d If Yes, Give Ye or Dates:	ar		1 X Yes	2 No	specify MI	EXICAN	Specify	/: ME	XICAN
hours matur Exam	ed	15. Decedent's Educa					ecedent's Usua Iring most of w				16b. Kind of	Business/I	ndustry
36 in 72 iran "	Completed	Elementary/Seconda	ry (0-12)	College (	1-4 or 5+)		CC	ООК			FOOD		
with with her the	mo	6 17. Father's Name (Firs	t Middle Las	1)					IS Mother's Na	me (First, Middle	FOOD	ne)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. 1 dates e Harrie (i ne			GARCIA	ARR	OYO	- [		ELENA			ADAMO
212 buld by Meni mark	To E	19a. Informant's Name/						ss (Street		or Rural Route N			
Baltimore, MD 21215-0036 gernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Mcdical Examiner must be notified at once.		GUS TAVO	GARC	[A –	UNCLE	5	WARD	AVE.	, WES	TMINSTE	ER, MD	21	157
G, C, L, and Healt Healt Fitem		20a. Method of Disposit		V			Disposition (Na y or other plac		netery,	Date	20c. Location	n - City or	
AOPages ent of nt: I		1 X Burial 2 0	Other Specif						9 ab	/29/06	STXTO	) VE	MEXICO RDUZCO
Baltir permit Departm Importa		2 Signatur Funera			9211	, ,	22. Name an	nd Address	of Facility F	LETCHEF	DIMEE	)	JOME
<b>0</b> 7 2 2 1 1							254 E	.MAI	N ST.	. WEST	ITNSTEE	IM S	
Physician		23a. Part I. Enter the di failure. List only o			caused the dea	th. Do not	enter the mode	e of dying,	such as cardia	c or respiratory a	rrest, shock, or h	neart	Approximate Interval 8etween Onset and
/Medical Examiner		Immediate Cause (Fina		Multiple In	•								Death
		or condition resulting in	death)	Due to (or as	a consequence	of):							
	er	Sequentially list conditi if any, leading to immed	diate	Due to (or as	a consequence	of):							<u> </u>
	Examine	cause. Enter Underlyin (Disease or injury that i											
ted I	Exa	events resulting in deat	h) Last	Due to (or as	a consequence	OT):							
Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial - transit	n/Medical	UNPENDED		AMENDED									
8760, tificate be ng physicas the buri	Med	IF FEMALE:		23c. If yes	outcome of pre	gnancy					23d Date	of delivery	,
687 ertific ding p	ian/	23b Was decedent pres past 12 months?	nant in the		birth	1 11	Fetal deat	h 3	Ectopic pre	gnancy	Month		ay Year
of Vital Records, P.O. Box 687 ing Physician: The law requires that the death certificate has been signed by the attending funeral director, page 2 should be detached for use as t	sicia	1 Yes 2 No 9	Unknow		nant at time of	death 5	Dther (Sp	ecify)					
D. B the d by the	Phy	Part II. Other significa	nt conditions		to death but not	resulting	in the underlyin	ng cause g	iven in Part I.	23e. Did	tobacco use cor	ntribute to	the cause of death?
P.O. es that to	l by									1Y	es 2 No	3 Prob	eably 4 🗸 Unknown
ds, requir	Completed									24a. Wa			topsy findings available
cor e law e has l	mpl									per	opsy formed?	death?	ompletion of cause of
		25. Was case referred t	o medical					26 Place	of Death (Che		2 No	1 🗸 Ye	s 2 No
/ita /sicial is cer	o Be	examiner?	7	Hospital: 1	Inpatient 2	ER/Out	patient 3		Dthor:	rsing Home 5	Residence 6	✓ Dther	Scene
n of \ ding Phy After th	_	1 Yes 2 27. Manner of Death	No	28a. Date	e of Injury th. Day Year) 1, 2006	28b. Ti	me of Injury	28c. Injur	y at Work?		how injury occu	rred	
OD endin sath or: A	ıtior	1 Natural 5	Pending		2006	2237	hrs	1 Y	es 2 🗸 No	Subject bid	cyclist involv	ed in ve	hicular accident
Division of Vital Records, rad or attending Physician: The law require and card the this certificate has been sided in by the funeral director, page 2 should be an up to the funeral director, page 2 should be a considered in by the funeral director.	ifice	2 Accident 3 Suicide 6	Investiga Could no	28e Pla	ce of Injury - At	home, fare	m, street, facto	ry, office bi	uilding, etc.			nber or Ru	ral Route Number, City
Dipital of purs a geral of filled	Certification:	4 Homicide	determin		) Local roa	d				e/B Rt-140	)-E/O Rt. 27	, Westm	ninister, Md.
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Founeral Director: After this certificompletely filled in by the funeral director.	al (	(Oncor only			-	-				and due to the ca			
To the within To the comple	Medical	- [2]		er: Dn the basis and manner		and/or inv				ed at the time, dat			
/	Σ	29b. Signature and title	of certifier	V			2	9c. License					nth, Day, Year)
4		Theother	M.	Fish.	JAIN	un		O.C.N	VI. ⊏.		Septemb	er 20, 2	UU6
7		30. Name and address Theodore M. K		-	use of death (Ite ant Medical			Denn Str	eet Raltim	pre, MD 2120	)1		
1				- 12	Registrar's Sign	-		eiiii oli	cei, bailim	DIE, WID 2120	, i		
S	tate	31. Date filed (Month, D	ຕິດວາດ	c Esa	regional a oigh	20	make?						

	•	~~~	-	-00	-	
State of Maryland / Department of	A S La milde in manifest than a self-fit to the second of	9 🖯	п	(-	1)	ġ
State of Maryland / Department (	it Health and Mental Hydlene				. 7 :	
- tatte of the jumps	, , , , , , , , , , , , , , , , , , , ,	- V		0		٩

		State Registrar	yland / Depa <i>Cel</i>	artment of H	ealth and I Death		g. No.	06 3015
Physici /Medic		Decedent's Name (First, Middle, Last)     MINNA	S	HAIVITZ		SEPT.	19 <sup>°</sup> , 2006	
Examin	er	4a. Facility Name (If not institution, give street and number)  JEWISH CONVALESCENT CENTER  5. Social Security Number 6. Sex 7. Age		4b. City, Town, or BALTIM				TIMORE
Funeral Director		5. Social Security Number  215-07-2614    6. Sex   7. Age   1	(In yrs. last birthday) 91 Yrs.	Months Days	Hours Min.	8. Date of Birth 06/12/1	915	Birthplece (State or Foreign Country) MD
Maryland a-f show	ctor	10a. State 10b. County N/A	10c. City, Town or Lo	TIMORE				10d. Inside City Limits 1   Yes 2 □ No
h with the 23a or 28 st be no	al Director	10e. Street and Number 5833 PARK HEIGHTS AVENUE		10f. Zip Code	21215	10	g. Citizen of Wha	t Country? USA
within 72 hours after death with the Maryland ene. Then "natural", or teme 23a or 28a-f ehow the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marned  3 Nowled 4 Divorced  12. Was Decedent Exammed Forces?  1 Yes, 2 Nowled Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (S n, Mexican, Puerti Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
be filed within 72 hours after death with the marylan kall Hydiene. Ad other then "natural; or Keme 23a or 28a-1 ehow event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0,12)  College (1-4or 5+	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, ESPERSON	lurina most of wor.	king	6b. Kind of Busin	
should be the nd Mental Hy marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) DAVID	COR	MAN	18. Mother's Nam BESSIE	ne (First, Middle, M	faiden Sumame)	LEVI
permit. Pages 1 and 2 should Depertment of Health and Men Important: If Item 27 is marks any injury or other treumatic. once.		ALLAN M. SHAIVITZ / SON  20a. Method of Disposition  1 (X) Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	20b. Place of Dispo cemetery, crei BETH TFIL	OH CEMETE  Name and Addres	RY 09/2	1/2006 0L LEVIN	WOODLA	y or Town, State
death certificate be executed  a eletending physicien and but as as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of): consequence of):					1 Month
ind the clearing phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent prefinant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
signed b	þ	Part II. Dther significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.			te to the cause of death?  Probably 4 Unknown
the law requir	Completed					24a. Was ar autops perform 1 Yes 2	prior deal	e autopsy findings available to completion of cause of h? Yes 2 □ No
To the Hospital or Attending Physicien: The law requires that the within 24 hours after death.  To the Funeral Director: Alter this certificete hes been signed by the completely filled in by the funeral director. page 2 should be detached.	Certification; To Be (	27. Manner of Death  1	/ - At home, farm, str	f 28c. Injury Work M 1 [] Y	H 41 Nursing H		nce 6 Other ( winjury occurred eet and Number o	Specify) or Rural Route Number,
the Hospital or Ania 24 hours effer the Funeral Dire	edicai Certi	4 Homicide building, etc.  29a. Certifier (Check only 2 Medical Examiner: On the basis of e	(Specify) my knowledge, deat	h occurred at the tim	e, date and place	City or Town	State)	or as stated
To the H within 24 To the F complete	Medi	29b. Signature and title of pertifier	d.	29c. License			d. Date signed (M	fonth, Day, Year)
Á		30. Name and address of person who completed cause of dea DR. IAN SUNSHINE 6210 F	oth (Item 23a) (Type, PARK HEIGH		BALT	IMORE, M	/	0-06
Sta Registr		31. Date filed (Month, Day, Year) 32. Figistrar SEP 2: 2 2006	s Signature	parte				

			1 - For State Registrar	of Maryland /	Depa <i>Cer</i>	rtment of H tificate of L	ealth and M Death	lental Hygid Reg	ene 20 (	06 30154
	Physici	an	Decedent's Name (First, Middle, Last)			EL 7.0		2. Date of Death Month	Day Y	3. Time of Death
	/Medic	al	SHIRLEY	- hod	5	ELIS 4b. City, Town, or	Leasting of Dooth	Septembe	r 20 20 4c. County of	
	Examin	er	4a. Facility Name (If not institution, give street and re GREATER BALTIMORE MED)		2	TOWSON	Location of Death		BALTIM	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 7 F	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	917	Birthplace (State or Foreign Country) MD
7	and A		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tox	wn or Lo	cation			-	10d. Inside City Limits
Man	a-f ehr	tor	MD BALTIMORE		BALT	IMORE				1 ☐ Yes 2 🌠 No
4	or 28	Funeral Director	10e. Street and Number			10f. Zip Code	21200	109	g. Citizen of Wha	at Country? USA
400	ne 23a	erai	6 POMONA SOUTH #4	ecedent Ever in U.S.	13. V	Vas Decedent of Hi	21208	ecify Yes or No-	14. Race -	American Indian.
III Z I Z I 3-0036	permit rages I and a should be filed within 72 flouts after beath win the waryar perment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itame 23a or 28a-f show any Injury or other treumatic event, it a Medical Examinar must be indiffed at once.	ρ	Armed	Forces? s 2 <b>(X)</b> No Give Dates:	ļ li	Yes, specify Cubar	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc. WHITE
בי ה	"natu	letec	15. Decedent's Education (Specify only highest grade completed		(Give	ent's Usual Occupa kind of work done of OO NOT use retired,	uring most of work	ing 16	6b. Kind of Busin	ness/Industry
7 7	r than	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)		ET TEACHE		[	DANCE	
מומי	d other	Be	17. Father's Name (First, Middle, Last)		CTLV	ED.		e (First, Middle, Ma	aiden Sumame)	OLMANCKY
	marke marke	၉	LOUIS  19a. Informant's Name/Relationship (Type, Print)		SILV	g Address (Street a	ANNA	al Route Number.	City or Town, Str	O 1 MANSKY
, K	and 2.3		VIVIEN DELUGG / DAUGHT			72ND STF				
	if of He if Itan or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	m State cemete	ery, cren	sition (Name of natory or other place	a) ¦			ty or Town, State
	ertmen ortant: Injury		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	REIH		OH CEMET  Name and Addres			WOODLA	
	Permission of the company of the com	6	May Len				30	L LEVINSOROAD - PI		E, MD 21208
	hysician /Medical Examiner		Due t	t caused the death. Do each line.	0	er the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
/ 7	2 H	iner	cause. Enter Underlying	oneupeanos a acreo o	s of)-					
) , 00 / 0	physicien and the burial-transit	Examiner	that initiated events c.	o (or as a consequence	e of):					=
	ysicien je buriš	dicai E	d							
	ing ph	Φ.	IF FEMALE:							
DIVISION OF VICE THE COLOR, F.O. BOX O	The may happen or wearing tripacent. The law requires trip bear committed to the committed of the committed	Physician/M	23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy birth 2 Fetal death gnant at time of death known		Ectopic pregnancy Other (specify)			23d. Date of Month	
ָרָ בְּלָּ מְיִ	gned by		Part II. Other significant conditions contributing to	death but not resulting	in the un	derlying cause give	n in Part I.	23e. Did toba	.cco use contribu	ute to the cause of death?
COLUS,	een sig	ted	ischemic Carol	iomyopa	the	1		1 ☐ Yes	2 No 31	Probably 4 Unknown
בייים פעד.	cete has b	Completed by			-0			24a. Was an autopsy performe	edi? dea	re autopsy lindings available or to completion of cause of hth? Yes 2 \(\sum \) No
Vital	certifi	Be	25. Was case referred to medical examiner?  1 Types 2 Tible Hospital:			2D DOA Othe		(Check only one)		
5	ter this	n; To	27. Manner ol Death 28a. Dat		. Time of	28c. Injury Work	4   Nursing Ho	me 5 Residen 28d. Describe how		
IVISION	eath. Ior: Afl	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	mar, Day 16aiy	Injury		/es 2 □No			
	efter d Direct J in by	Certification:	determined 200. Fla	ce of Injury - At home, I Iding, etc. <i>(Specify)</i>	larm, stre	eet, factory, office		28l. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
- 6	hours uneral		29a. Certifier 1 Certifying Physicien: To t	he best of my knowleds	ge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and mann	er as stated.
4	thin 24 the F mplets	Medical		anner stated.		29c. License				Month, Day, Year)
F	- M L	_	Marie Caatta			D 20			120/01	, , , , , , , , , , , , , , , , , , ,
	9		30. Name and address of person who completed ca		) (Type, I		141		, 7, 6	
	Sta	to	Marie Chatha 31. Date filed (Month, Day-Year) 32	Registrar's Signature						
	Registr		SEP 2 2 2006	March 18	Spa	de				

State of Maryland / Department of Health and Mental Hygiene 2006 30155 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 1145 AM **Physician** CHARLOTTE MALLWED /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BRUTIMERE MERCY MEDICAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1□M 2/1 F 216-01-1119 MD. 28 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 27 is marked other then "neturel", or Items 23a or 28a-f show traumatic event, it a Miccial Examinar must be mutified at 1 √ Yes 2 No BALTIMORE Director MD. N/A 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 21224 431 FOLCROFT ST. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If term 27 is narrived other traumant in only not other traumants. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOME MAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CHARLOTTE FORWOOD RICHARD HUGHES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 431 FOLCROFT ST., BALTIMORE, MARYLAND 21224 SHARON STAVROPOULOS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 9/18/06 BALTIMORE, MARYLAND WOODLAWN CEMETERY 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 21. Signature of Fyneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burief-transit been signed by the ettending physicien and should be detached for use as the buriel-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown PISLMONTY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ No this 28c. Injury at Work? To the Funeral Director: Alter th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier f Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPTEMBER 14, 2006 1)474 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 361 51. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

06-07048 Louis Terrell

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 30156

		1- For State Registrar	Certific	cate of	Death		R	leg No.	
Physici		1. Decedent's Name (First, Middle,Last)	1 1				Date of Dea    Month	Day Year	3. Time of Death
Medical Exam	ner	Louis Freeman Ter					Septembe	er 18, 2006	0946 hrs
		4a. Facility Name (if not institution, give street and nur Bon Secours Hospital	nber)	4	b. City, Town, or Lo Baltimore	ocation of Death		4c. County o	f Death
Funeral			7. Age (In yrs. last bii	rthday)	If Under 1 Year  Months Days	If Under 24Hrs Hours Min.	_	· ·	Birthplace (State or Foreign
Director		214-52-8537 1XXM 2_F	53	Yrs.	I WIOTILITS Days	Tiodis Iviiii,	09-2	4-1952	Country) MD
Á		Usual Residence of Decedent  10a. State 10b. County	10c. City, Towr	o or Longtin	20				10d Inside City Limits
0 w ai		MD Baltimore		imor					1 Yes 2 X No
Maryland 28a-f show any d at once.	ģ	10e. Street and Number	Dait	TINOL	10f. Zip Code			Og, Citizen of Wh	
or or	Director	309 Winter Lane				1228		US	*
n with the ms 23a	Funeral		dent Ever in U.S.		Decedent of Hispa s, specify Cuban, I				- American Indian, Black,
death or ite	'n	1 Yes	2 X No		s, specily Cuban, i	Mexicall, Fuelto	Ricari, etc.)	White	
s after ral", tiner	ģ	Widowed 4 Divorced If Yes, Give Year or Dates:			Yes 2 X No			Specify:	Black
hour hour	ted	15. Decedent's Education (Specify only highest grad  Elementary/Secondary (0-12) College (1-			's Usual Occupation st of working life. D			16b. Kind of Bus	siness/Industry
15-0036 filed within 72 hours after o Hygiene ed other than "matural", o t. the Medical Examiner n	Completed	College (1-	40(3+)	Dr	iver			Li	very
d wit	5	17. Father's Name (First, Middle, Last)			18	B.Mother's Name	(First, Middle,	Maiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene marked other than c event, the Medica	8	Franklin Terrell				Glori	a C. H	Holland	
21 Should and Me is ma	은	19a. Informant's Name/Relationship (Type, Print) Gloria C. Terrell/m			Address (Street a				
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic	Ů	20a. Method of Disposition			ion (Name of ceme		Date Date		re MD 21228 City or Town, State
Baltimore, permit Pages I a Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from	m crema	tory or other	er place)	.			
ti Pag tment rtant:		4 Donation 5 Other Specify:	Cires					No ReT	tsville, MD
Baltimore permit Pages   Department of F Important: If i		21 Signature of Funeral Service Licensee	1211112	8 7	ame and Address o	n Past	FA ures I	r Balt	21236 imore MD
Physician	-	23a. Palt I Enter the disease, or complications that ca	used the death. Do n						and the second s
/Medical		failure. List only one cause on each line	lerotic card	liovaco	ular dispa	50			Between Onset and Death
Examiner		and the second second	consequence of):	itovasc	uiai uisca	<del>5C</del>			_
		Sequentially list conditions, b							
	ē	cause. Enter Underlying Cause	consequence of):						
_ #	Examiner	d disease or injury that initiated	consequence of):						-
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		d							
7 <b>60,</b> cate be execut physician and he burial - trau	n/Medical	X UNPENDED AMENDED	item#23a,27	,perÆ	1,g859,9/26,	/06 TT			
8760, tificate bong physicas as the bun	Ž		utcome of pregnancy th		ol dooth 3	Ectopic pregna	nev	23d. Date of o	delivery Day Year
x 68 h certi endin use a	<u>cia</u>	4 Pregna	and the Control of the other		er (Specify)		ricy	Worter	Day Teal
Box 6 e death cert the attendi	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	wn						
tal Records, P.O. Box 6i cian: The law requires that the death cert certificate has been signed by the attendit ector, page 2 should be detached for use a	by P	Part II. Other significant conditions contributing to	death but not resultir	ng in the ur	nderlying cause give	en in Part I.			oute to the cause of death?
S, F urres na sign	pa								Probably 4  Unknown
ord aw rec as bee	Completed						24a Was autop	osy pr	/ere autopsy findings available ior to completion of cause of
Rec The L	팃						1 Yes		eath? ✔ Yes 2 No
tal   cian: certifi	BB	25. Was case referred to medical examiner?				f Death (Check			
Physic r this	2	1 Yes 2 No	patient 2 🗸 ER/C					Residence 6	Other.
Division of Vital Records, tal or Attending Physician: The law requir rs after cleath.  al Director: After this certificate has been seled in by the funeral director, page 2 should!	띪	27. Manner of Death  1 X Natural  5 Pending  28a. Date of (Month,	Day,Year)	Time of Inj		at Work? s 2 No	28d. Describe	how injury occurre	d
ivisior  or Attend after death Director:	ati	2 Accident Investigation	of lower At home (				000 1 /	01 11 111	5 15 1 N 1 0
Divi	Certification:	Suicide Could not be determined (Specific)	of Injury - At home, f	rarm, street	, factory, office buil	laing, etc.	or Town, S		r or Rural Route Number, City
ie ou		29a. Certifier	of my knowladge, do	ath occurr	ad at the time, date	and place and	due to the cour		no stated
# # # m	Medical	one) 2 Medical Examiner: On the basis o	examination and/or						
To with	Mec	and manner st 29b. Signature and title of certifier	ated.		29c. License r	number		29d. Date signe	d (Month, Day, Year)
		aug DZ			O.C.M.	.E,		September	19, 2006
<b>P</b> (A)	i	30. Name and address of person who completed causi	e of death (Item 23a)						
<b>W</b>		Ana Rubio MD. Assistant Medical E		Penn St	reet, Baltimore	e, MD 21201			L.
		31. Date filed (Month, Day, Year)	gistrar's Signature	Locale	,		-		
Regis	trar	SEP 2 2 2006 Marie	UN A	The same					

			For State Registrar	State of Marylan		artment of F			giene Reg. No. 200	16	301	57
	Physici		Decedent's Name (First, Middle, Last)	WEITZEL				2. Date of Dea		3.	Time of D 2:54	
}	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of De	<del>_</del>	4c. County of [		ore	
	Funeral Director		5. Social Security Number 217-12-9979	7. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		, Yaar 9.	Birthplace Mary	(State or I	Foreign
	iryland show	_	Usual Residence of Decedent  10a. State 10b. County  MD	10c. Ciț	y, Town or Lo	cation Baltimo	re	, , , , , , , , , , , , , , , , , , , ,			nside City	
	ith the Ma or 28a-f	Director	10e. Street and Number 940 South Lake		Apt.	10f. Zip Code			10g. Citizen of Wha	it Country?	Yes 2	!   No
	death wi	Funeral [		12. Was Decedent Ever in U. Argred Forces?	304 S. 13.	212 Was Decedent of H	ispanic Origin?	(Specify Yes or No-	USA 14. Race - A		ndian,	
3036	iours after iral', or ite Exemine	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∰Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	orio riioari, oto.)	Specify:	ville, etc.	Whi	.te
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mennal Hygiene. Is marked other then "natural", or items 23s or 28s-f show aumatic event, the Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired a Keman	during most of w	working	Railro		у	
and 2		To Be Co	17. Father's Name (First, Middle, Last)  Jacob Weitzel					lame (First, Middle, ce Schel		ıger		
Mary		Ĕ	19a. Informant's Name/Relationship (Ty, Marlene Hronows		19b. Mailin 1805	ng Address (Street	and Number or fe Roa	Rural Route Numbe ad-Parkv	r, City or Town, Sta ille, Ma:	te, Zip Cod rylai	nd 2	1234
Baltimore,	of H		20a. Method of Disposition  1 Burial 2 Tremation 3 R  4 Donation 5 Other (Specify)	emoval from State $EV^{c}$	emetery, cren ins Fu	sition (Name of natory or other plan ineral f L-Air	fome 9-	Date - 21 - 06	20c. Location - City Fores			D
Balt	permit. Pag Department important: eny injury o		21. Signature of Funeral Service License	1= tastol	4		ss of Facility I	EVANS CH bad-Park	APEL OF Ville,M	MEMO D 212	ORIES 234	s
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause on each line.	Can	er the mode of dyir	g, such as card	liac or respiratory are	est,	Inte	proximate erval Betwe set and De	en eath
8760, g	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)								
. Box 6	death certifi e ettending od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy			23d. Date of Month	f delivery Day	Ye	)ar
rds, P	sign 1 be	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did (fo	bacco use contribu ies 2□No 3□	te to the ca		
<u> </u>	The ete h page	Completed						24a. Was a autop: perfor 1 Yes	mpd2 prior deat	e autopsy f r to complet th? Yes 2	tion of cau	railable use of
	Physicien: The lav this certificete has al director, page 2	To Be	25. Was case referred to medical examiner? 1 \( \subseteq \text{Yes}  \text{2} \subseteq \text{No} \)		ER/Outpatien	1000	er: 4 🗆 Nursing	Death <i>(Check only or</i> 3 Home 5 🗆 Resid	1/	Specify) V	losp1	10
Division of	ter Ter		27. Manner of Feath  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No	28d. Describe h	ow injury occurred			
_	F # F C	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	<i>(</i> )			City or Tow				ar,
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier Check out 2 Medical Examinone)	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	n occurred at the tir vestigation, in my o	ne, date and pla pinion, death oc	ace, and due to the c ccurred at the time, d	ause(s) and manne late and place, and	r as stated due to the	cause(s)	
)	To t To t	Σ	29b. Signature and the of certifier	luv		29c, Licens	-		29d. Date signed (N Scotem			LOOK
	3+1		30. Name and address of person who co	mpleted cause of th (Item	60 N	Print Char	les st	S SALVINO	emp.	2120	74	
18.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Angell 5					/	

			. 101	epartment of Health and M Certificate of Death		ne 2006 30158	3
	Physicia		1. Decedent's Name (First, Middle, Last)  Willie William S		2. Date of Death Month September	Day Year 3. Time of Death	
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Genesis Loch Raven	Towson	O. Data of Birth	Baltimore	
н	Funeral Director		5. Social Security Number 6. Sex 1 $\times$ 4 $\times$ 4 $\times$ 7. Age (In yrs. last birth 186-03-4027	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. 5–20–19]		)
	ס		Usual Residence of Decedent		<u> </u>		
	show	ŏ	10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	28a-f	Director	Md. NA Balt	imore	10g.	Citizen of What Country?	_
	3a or	i D	1336 Stonewood Road	21239		USA	
	ems 2	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	_
36	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give   3 및 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black	
8	2 hour	ted	15. Decedent's Education 16a. D	Decedent's Usual Occupation	16b	b. Kind of Business/Industry	_
21215-0036	ithin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of worki ife. DO NOT use retired)			
22	filed with Hygiene. other ther ent, the N	Co	11th grade  17. Father's Name (First, Middle, Last)	Welder	(First, Middle, Maid	Shipyard	
Maryland	d da d	To Be	Willie Williams	Albert	•	Harris	
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. I	Mailing Address (Street and Number or Rura			
	1 and 2 Health em 27 l		1	553 W. Carpenter Land			
Baltimore,	Pages 1 nent of H int: If iter iry or oth		1  Burial 2  □ Cremation 3  □ Removal from State	crematory or other place)		: Location - City or Town, State	
Ħ	permit. Page Department of Important: If eny injury or once.	1	* 4 Donation 5 □ Other (Specify) Trini  21. Signature of Juneral Service Licensee	ty Cem. 9-29-	-06 Di arch F.H.	undalk, Md. East	-
å	Depa Impo eny ir		Do nulla.	1101 E. North Aven			
Ŋ,			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	e of Kung		Onset and Death	
	/Medical Examiner		Due to (or as a consequence of	500	) }	Hanna	
	NE DE	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	):		- gen-	
8.	ecuted and transi	Examine	Cause (Disease or injury that initiated events c.				W
8760,	The law requires that the death certificate be executed tae has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	al E	Due to (or as a consequence of	<i>.</i>			
9	ifficate g phys as the	ledical	d				
Вох	eath certific attending p for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery  Month Day Year	
P.O. F	the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)		WOMIT Day real	
	res that the designed by the a		Part II. Other significant conditions contributing to death but not resulting ig t	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?	
rds	w requires been sign should be	ed by	teripheral artery de	sease	1 ☐ Yes	2 No 3 Probably 4 □Unknown	
Vital Records,	law requ as been 2 should	Completed	Antic Stendsis		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	,
<u>س</u>	ilcien: The lav certificate has rector, page 2	Con			performed 1 ☐ Yes 2/X	No 1 ☐ Yes 2 ☐ No	
<u> </u>	sicien certifi irector	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.	26. Place of Death atient 3 DOA Other: 4 X Nursing Ho		a 6 ☐Other (Specify)	-
) of	ding Phys h. After this funeral di	n: To	27. Manger of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at	28d. Describe how in		1
sior	ttendin death. ctor: Aff , the fur	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of	l or Atten after deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)	
	spital	ai C	29a. Certifier 1 Sertifying Physician: To the best of my knowledge,	death occurred at the time, date and place,	and due to the cause	ə(s) and manner as stated.	
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.		ed at the time, date a	and place, and due to the cause(s)	
}	To T	Σ	29b. Signature and title of capitles My My	29c. License number	) 4	Date signed, (Month, Day, Year)	
	3		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	21 01	H MD 21200	
			31. Date filed (Month, Day, Year)  32 Registrar's Signature	6331 perais 1	d Pal	NO 142/206	-
	Sta Registr		SEP 2 2 2006	parti			

無		1 - For Stata Ragistrar  1. Decedent's Name (First, Middle, Last,		-	001	incat		Journ		2. Date of De	ath		3	301
iysici Medic		LINGARD EDWARD W	INKLER							SEPT	. Day	3 20ď	ar O	10:1
camin		4a. Facility Name (If not institution, give Union Hospital	street and numb	er)			Town, or kton	Location of	Death		4c.	County of C		
neral ector	VG	5. Social Security Number 6. Security Number 6. Security Number 1 X	7. M 2 F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2- Hours	Min.	8. Date of Bir (Month, Da April			Birthplace Country) lary1	
=	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d.	Inside City
office	Director	Maryland Cecil  10e. Street and Number			North	East 10f. Zin					10a Citis	zen of What	Country	1 ☐ Yes 🎗
87 78	i Di	17 Alicia Ct.				101. 23	219	001			rog. Oitiz	USA	Country	•
other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2€€Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	os? □ No 		Vas Dece Yes, spe		spanic Origi n, Mexican, Specify:	in? (Spec Puerto F	cify Yes or No tican, etc.)	1	4. Race - A Black, V Specify:	/hite, etc.	
dical E		15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	kind of wo	rk done d	turina most d	of workin	g		nd of Busine		
IDe Me	Completed	Elementary/Secondary (0-12)	College (1-4 N/A	or 5+)		ονοτώ ilder		') -			Sela	E⊸Emp]	Loyed	1
event,	Be	17. Father's Name (First, Middle, Last)								(First, Middle,				
matic	2	Edward Joseph Wink			19b. Mailin	a Address	(Street a		'	e Eliza  Route Numbe				
er trau		Mrs. Shelley Devea	, , ,	veice)		-				st, Md			O, 2.p 00	
eny injury or other Once.		20a. Method of Disposition  XXXBurial 2 ☐ Cremation 3 ☐ F	lemoval from Sta	ate	Place of Dispo- cemetery, cren	natory or o	ther plac	-		ite		ation - City		
injury P		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	98	Ho]	Ly Rosa:	-		-		2006	Balt	cimore	e, Mo	
eny ir		Mother 1882	cho ()	TAG		Las 740	sahn 1 Be	s of Facility Fune: lair F	ral   Rd.	Home Baltimo	ore.	Md. 2	1236	
		23a. Part1. Enter the disease, or compl shock, or heert failure. List only or Immediate Cause (Final	ications that cause on each	sed the dea h line.	th. Do not ente								Ap	proximate erval Betwe set and Dea
cian Iical		disease or condition resulting in death)	Due to (or	as a consec	uence of):	-	-4-2	. D					1	MON
ner		Sequentially list conditions,	·	Asp	Trati	Sprr		n Pneu	IIKOLLL	.d		<u></u>		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):									
ומו.ח	Exa	that initiated events resulting in death) Last	Due to (or	as a consec	quence of):	·								
ine Di	dicai	•	d										-	
should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ∏ Feta t at time of c	aldeath 3	Ectopic pr Other (sp					2	3d. Date of Month	delivery Da	y Yea
detac		Part II. Other significant conditions con	ntributing to deat	h but not res	sulting in the un	derlying c	ause give	n in Part I.		23e. Did to	obacco us	se contribut	e to the c	ause of dea
200	ted by	Hyperten	SIOW							101	∕es 2□	]No 3 [	Probably	∕ 4 SUnk
, page z sn	Completed	`					-			24a. Was autop perfo	an osy rmed? 2 X No	prior	to compte	findings ava ation of caus No
lirecto	o Be	25. Was case referred to medical examiner?	lospital:	atient 2	ER/Outpatien	3 DC	Othe			(Check only o e 5∐ Resid		COther (6	·	
ne funeral o	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of I		28b. Time of Injury		Bc. Injury Work		28	Bd. Describe h			рвспу	
completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	building,	etc. (Speci						Bf. Location (S City or Tou	vn, State)			
letely fi	edicai	29a. Certifier Certifying Physical Community Classics (Classics only one)	sician: To the be ner: On the base and manner	s of examina	owledge, death ation and/or inv	occurred	at the tim , in my op	e, date and pinion, death	place, ar occurre	nd due to the d d at the time, i	cause(s) a date and p	and manner place, and o	as stated	d. cause(s)
comp	ž	29b. Signature and title of certifier	1.				License				29d. Date	signed (Mo	onth, Day	, Year)
			a) ct			7	100	583	150	1	09	191	06	
		30. Name and address of person who co	m nlate d =		- 00e) CT			3 0		,		1		

WINKLER

			Please Type or P					-		egible.	
			1 - State of I	Maryland / [		artment of H rtificate of	lealth and M <i>Death</i>	fental Hy	_	2006	30160
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Mary Benson Walburn					2. Date of Do Month SEPT		Year 2006	3. Time of Death 5:55 A M
	n 72 hours after death with the Maryland  "naturel", or Itema 23e or 28e-f show adical Examiner must be nutillare at	Funeral Director	4a. Facility Name (If not institution, give street and number ST ACNES HOSPI  5. Social Security Number 6. Sex 1 M 2 F 7  220-14-4882 1 M 2 F 7  Usual Residence of Decedent 10a. State 10b. County  Maryland Baltimore 10e. Street and Number 404 Montemar Ave.  11. Marital Status 12. Was Deceded.	Age (In yrs. last bin 91 10c. City, Town Cato	Yrs.	BAL  If Under 1 Year  Months Days  cation  ille  10f. Zip Code  2	Hours Min.	B. Date of Bi Month, Nove	10g. Citize		
2-0030	thours after of ture!, or iter	by	Armed Force  1 Never Married 2 Married 1 Yes 2  3 Widowed 4 Divorced Paar or Date  15. Decedent's Education	os? D∰o s:	Deced	1 ☐ Yes 2 ☐ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:		S	Black, White,	etc. ite
	- 32	e Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  12  College (1-4c)  17. Father's Name (First, Middle, Last)		(Give life. L	kind of work done DO NOT use retired	during most of working  ic Teache  18. Mother's Name	er	Balt	imore Co ol Syste	ounty
ıryıand	should be ind Mental I	To Be	Charles J. Benson  19a. Informant's Name/Relationship (Type, Print)	19b.	. Mailin	ng Address (Street	Mary E.	Armac	ost		(Code)
ore, ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny injury or other traumatic event, the Magnee.		Charles Walburn - son  20a. Method of Disposition  1 MBuriai 2 Cremation 3 Removal from Sta	20b. Place of cemeter	Dispo	7 Kettled sition (Name of natory or other place	rum Ct.,	Ellico	tt Ci	ty, Md.	21042 own, State
baltimor	permit. Pag Department Important: eny injury once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	St. Pa			Cem. Sept ss of Facility uneral Ch terstown			- ~	•
1	To the Hospital or Attending Physician: The law requires that the death certificate be executed XX within 24 hours after death.  Yet the Anours after death.  Yet the Anours after death.  Yet the Eunerel Director: After this certificate has been signed by the attending physician and Director. After this completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of Director.	dical Examiner	Due to (or  Sequentially list conditions, Tary leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a	S of):	er the mode of dyin	ig, such as cardiac c	or respiratory a	arrest,		Approximate Interval Between Onset and Death Tology S
.O. DOX	the death certify the attending ached for use as	Physician/Medi		2 Fetal death at time of death		Ectopic pregnancy			23	d. Date of delive Month	ory Day Year
cords, r	w requires that been signed E should be deta	Completed by PI	Part II. Other significant conditions contributing to dealt  Coronary array c  Hypothypoidism					1 🗆	Yes 2	No 3□Prob	
ומו	lan: The lav	Be Comp	25. Was case referred to medical examiner?				26. Place of Death	24a. Was autop perfo 1 Yes	osy ormed? 2 No	prior to condeath?	psy findings available inpletion of cause of
	lending Physic eath. or: After this co	Certification: To	1 Yes No Hospital: 1/2 Inpa  27. Manner or Leath  10 Natural 5 Pending 2 Accident investigation  1 Pospital: 1/2 Inpa  28a. Date of Ir  (Month, II			28c. Injun Wor	4   Idai sing Hor	ne 5 Resi			J
ב <u>ר</u>	pital or Att burs after di lerel Direct filled in by t		4   Homiciae building,	Injury - At home, far etc. (Specify)				City or To	vn, State)	Number or Rura	
1	To the Hos within 24 ho To the Fun completely	Medical	(Check only one) C2 Medical Examiner: On the basis and manner	s of examination and stated.	Vor inv	estigation, in my o	pinion, death occurre	ed at the time,	date and pl	lace, and due to	the cause(s)
	Sta Registr	ite ar	30. Name and address of person who completed cause of MARIA CARMELA R  31. Date filled (Month Pay Year) 2006	strar's Signature	Service Servic	AGNE	3 HOSP	ITHL		Balto, M	1. 21229

		Registrar		21,000g	rtificate of	Death		giene 200	6 3016
		1. Decedent's Name (First, Middle, Last,	)				2. Date of Dea	ith Day Yea	3. Time of Death
/sicia ledica		Clara L. Arcile	si					ber 6. 20	n M
amine		la. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea		4c. County of D	
		Montgomery Genera	l Hospital		01ney				ontgomery
eral tor		5. Social Security Number 6. Sec. 10 6. Sec. 10 10 10 10 10 10 10 10 10 10 10 10 10	7. Age (//	n yrs. last birthday) 87 Yrs.	Months Days	Hours Min	. (Month, Da	h v, Year) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Birthplace <i>(State or Foreig</i> <i>Country)</i> est Virginia
	-	Usual Residence of Decedent		07			pehr. I	4, 1910 W	est virginia
	-	10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	٥	Maryland Montgom	erv	Si	lver Spri	na			1 ☐ Yes 20 No
	Director	10e. Street and Number		-	10f. Zip Code	J		10g. Citizen of What	Country?
		3330 N. Leisure	World Blvd	1., #311	20906	5		USA	
	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 25 No	an, Mexican, Pue	Specify Yes or No nto Rican, etc.)	14. Race - A Black, W SpecifyWh	
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	edent's Usual Occup wind of work done DO NOT use retire	during most of we	orking	16b. Kind of Busine	ss/Industry
	ភ្ជ	12		Home	maker			Own Hom	2
	Be	17. Father's Name (First, Middle, Last)			•	18. Mother's Na	me (First, Middle,	Maiden Sumame)	
	၉	William A. Bell				Geor	gie Sigl	er	
	].	19a. Informant's Name/Relationship (T)			•			r, City or Town, State	
	-	Anthony S. Arciles:				700d Driv		, Marylan	
		20a. Method of Disposition 1	Removal from State	20b. Place of Dispo cemetery, cre Arlington N	matory or other pla	Ser	Date ot. 19, 2006	20c. Location - City	
Name of the last		21. Signature of Funeral Service Licens	molay				Funeral	Home Inc ver Sprin	•
	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it cay, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	onsequence of): onsequence of): onsequence of):	sis Secres				I day
11/4	0							I	
	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	☐Fetal death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3[ ne of death 5[	Other (specify)			Month	Day Year to the cause of death?
	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3[ ne of death 5[	Other (specify)		24a. Was autop	Month  bbacco use contribute  fes 2 No 3   an 24b. Were sy prior death	Day Year  to the cause of death?  Probably 4 Tonknow  autopsy findings available to completion of cause of?
	e Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions co	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3[ ne of death 5[	Other (specify)	ven in Part I.	24a. Was autop perio 1 \( \text{Yes}	Month  obacco use contribute  fes 2 No 3   an 24b. Were  isy rined? death  2 No 1 No 1	Day Year  to the cause of death?  Probably 4 Tonknow  autopsy findings available to completion of cause of?
	Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions co	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 [ne of death 5 [	Other (specify) _	ven in Part I.  26. Place of De	24a. Was autop perfo	Month  obacco use contribute  fes 2 No 3   an 24b. Were  isy rined? death  2 No 1 No 1	Day Year  to the cause of death?  Probably 4 Tonknow  autopsy findings available to completion of cause of ?  es 2 No
	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	Petal death 3 [ne of death 5 [	Other (specify) underlying cause graint 3 DOA Other	ven in Part I.  26. Place of Dener: 4 □ Nursing	24a. Was autor performed to the control of the cont	Month  obacco use contribute  fes 2 No 3   an 24b. Were prior death 22No 1 No 1	Day Year  to the cause of death?  Probably 4 Onknow  autopsy findings available to completion of cause of ?  es 2 No
	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions co    Demenha	1 Live birth 2 [ 4 Pregnant at tim 9 Unknown  ntributing to death but n  COP) ASI	Petal death 3 [ne of death 5 [ne of death 5 [ne of death 5 ]]  Door resulting in the uncertainty of the unce	Other (specify) underlying cause grant 3 DOA Other  and 3 DOA Other  M 1 1	26. Place of Dener: 4 \( \triangle \	24a. Was autop perfo 1 Yes eath (Check only o 28d. Describe Mark 1 28d.	Month  bbacco use contribute  (es 2 No 3 Contribute  an 24b. Were prior death  22 No 1 No 1 No No No No No No No No No No No No No	Day Year  to the cause of death?  Probably 4 Onknow  autopsy findings available to completion of cause of ?  es 2 No
	Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death  1   Matural   5   Pending investigation   3   Suicide   4   Homicide   Homicide    29a. Certifier   1   Certifying Physical Interest   Certifying Ph	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y 28e. Place of Injury 28e. Place 08e. Place 28e. Petal death 3 [ne of death 5 []  not resulting in the uncertainty of t	Other (specify) underlying cause grant 3 DOA Other of 28c. Inju Wo M 1 treet, factory, office	26. Place of Dener: 4 Nursing ry at rk?  I Yes 2 No	24a. Was autop performed to the control of the cont	Month  bbacco use contribute  fes 2 No 3   an 24b. Were prior death 1 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	Day Year  Day Year  To the cause of death?  Probably 4 Onknow  autopsy findings available to completion of cause of essential endings.  Proceedings available to completion of cause of essential endings.  Proceedings available to completion of cause of essential endings.	
	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions co  25. Was case referred to medical examiner? 1   Yes 2   No 27. Manner of Death 1   Matural   5   Pending investigation   3   Suicide   4   Homicide   Could not be determined  29a. Certifier   1   Certifying Phy (Check only 2   Medical Examined)	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of Injury building, etc. (resician: To the basis of existence of the part of the p	Petal death 3 [ne of death 5 []  not resulting in the uncertainty of the control	ont 3 DOA Office th occurred at the truestigation, in my of the occurred at the truestigation, in my office the occurred at the truestigation, in my office the occurred at the truestigation, in my office the occurred at the truestigation, in my office the occurred at the truestigation, in my office the occurred at the truestigation, in my office the occurred at the truestigation, in my office the occurred at the true occurred	26. Place of Dener: 4 Nursing ry at rk?  I Yes 2 No	24a. Was autop performed at the time, and due to the surred at the time,	Month  bbacco use contribute  fes 2 No 3   an 24b. Were sy prior death 22 No 1 No ne)  dence 6 Other (S now injury occurred  cause(s) and manner date and place, and (Mo	Day Year  to the cause of death?  Probably 4 Onknowr  autopsy findings available to completion of cause of? es 2 No  Pecify)  Rural Route Number,  as stated, tue to the cause(s)
	edical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions co  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural   5   Pending investigation 3   Suicide   4   Homicide   Could not be determined  29a. Certifier   (Check only one)   1   Certifying Phyone)   2   Medical Examination   2   Medical Examination   1   Certifying Phyone)   2   Medical Examination   1   Certifying Phyone)   1   Certifying Phyone)   1   Certifying Phyone)   1   Certifying Phyone)   1   Certifying Phyone   2   Medical Examination   2   Medi	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of Injury building, etc. ( 28in To the basis of example and manner stated  MEAN 1.	Petal death 3 [ne of death 5 []  not resulting in the uncertainty of t	ont 3 DOA Office Industries, factory, office th occurred at the transcription, in my contract of the contract of the occurred at the transcription, in my contract of the occurred at the transcription, in my contract of the occurred at the transcription of the occurred at the transcription of the occurred at the transcription of the occurred at the	26. Place of Dener: 4 Nursing  Yes 2 No  me, date and place opinion, death occurs on the complete of the compl	24a. Was autoperformed at the time,	Month  bbacco use contribute  fes 2 No 3   an	Day Year  to the cause of death?  Probably 4 Onknown autopsy findings available to completion of cause of? es 2 No  Procify)  Rural Route Number, as stated, tue to the cause(s)
pietely filled in by the tuneral director, page 2 should be detached for use as	edical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions co  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural   5   Pending investigation 3   Suicide   4   Homicide   Could not be determined  29a. Certifier   (Check only one)   1   Certifying Phyone)   2   Medical Examination   2   Medical Examination   1   Certifying Phyone)   2   Medical Examination   1   Certifying Phyone)   1   Certifying Phyone)   1   Certifying Phyone)   1   Certifying Phyone)   1   Certifying Phyone   2   Medical Examination   2   Medi	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of Injury building, etc. ( 28in To the basis of example and manner stated  MEAN 1.	Petal death 3 [ne of death 5 [ne of death 5 [ne of death 5 [ne of death 5 [ne of death 5 ]]  2 ER/Outpatier  28b. Time of Injury  - At home, farm, st  Specify)  my knowledge, deat amination and/or ind.	ont 3 DOA Office Industries, factory, office th occurred at the transcription, in my contract of the contract of the occurred at the transcription, in my contract of the occurred at the transcription, in my contract of the occurred at the transcription of the occurred at the transcription of the occurred at the transcription of the occurred at the	26. Place of Dener: 4 Nursing  Yes 2 No  me, date and place opinion, death occurs on the complete of the compl	24a. Was autoperformed at the time,	Month  bbacco use contribute  fes 2 No 3   an	Day Year  b to the cause of death?  Probably 4 Onknow autopsy findings availate to completion of cause of the

		1 - For State Registrar	State of M	laryland / Depa		lealth a	nd Mental Hy		11116	30162
Physic /Med	ical	Decedent's Name (First, Middle, Last)     SANTIAGO ACOSTA  4a. Facility Name (If not institution, give s	treet and numbe	rl	4b. City, Town, or	r Location of	2. Date of De Month SEPTEMB	ER 8	Year 2006 County of Death	3. Time of Death 3:45 AM
Exami		511 ZAIDEE LANE 5. Social Security Number 6. Sex		., Age (In yrs. last birthday)	STEVENSV.			QUI	EEN ANNE	
Funeral Director		580-34-2259 Usual Residence of Decedent	M 2□F	76 Yrs.	Months Days	Hours	06/19/1	930 (930)	PUER'I	lace (State or Foreign htry) ORICO
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show its Madical Examiner must be notified at	ector	10a. State 10b. County  MD QUEEN ANN	e's	10c. City, Town or Lo	LLE					0d. Inside City Limits 1 ☐ Yes 2 📉 No
ath with the 23a or 2	eral Dire	10e. Street and Number 511 ZAIDEE LANE			10f. Zip Code 21666			USA	en of What Coun	
5-0036 72 hours after dea "natural", or Itams	by Funeral Director	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	<ol> <li>Was Deceden Armed Forces</li> <li>Yes 2 If Yes, Give Year or Dates</li> </ol>	1953-	Was Decedent of H If Yes, specify Cuba 1 X Yes 2□ No	Specify:	in? (Specify Yes or No Puerto Rican, etc.)		4. Race - Americ Black, White, Specify:	etc.
Ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other treumstic event, the Mudical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation	1973 16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation			WHI d of Business/Inc	
tind 21 be filed wintal Hygien and other th	Be	17. Father's Name (First, Middle, Last)	4	LT. (	COLONEL		's Name (First, Middle		ARMY Sumame)	
Maryland of 2 should be file th and Mental Hy t7 is marked oth treumatic event	70	SANTIAGO ACOSTA  19a. Informant's Name/Relationship (Type		19b. Mailii	ng Address (Street	-	M. LOPEZ or Rural Route Numb	er, City or	Town, State, Zip	Code)
more, M Pages 1 and 3 nent of Health int: if Item 27 iny or other tre		MAUREEN ACOSTA / S  20a. Method of Disposition  1  Burial 2	POUSE emoval from State	20b. Place of Dispo cemetery, crea	sition (Name of matory or other place	e)	EVENSVILLE Date		21666 eation - City or To	wn, State
Baltimore, permit. Pages 1 au Department of Hea Important: If Item eny injury or othe		4 Donation 5 Other (Specify) 21. Signature 1 February License	1/				9/11/2006 EIN & NEWN		/ENSVILLI INERAL HO	
Physician	5 1	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	cations that cause on ea	ed the death. Do not ent line.	er the mode of dyin		, CHESTER, ardiac or respiratory a		21619	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		is a consequence of):	incer			-		syrars
760, le be executed ysician and e burial-transit	cal Exan	that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
VISION Of VITAI HECONDS, P.O. BOX 68/6U, Attending Physicien: The law requires that the death certificate be executed refeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23	3d. Date of delive Month	ry Day Year
quires that the signed by uld be detact		Part II. Other significant conditions con	nbuting to death	but not resulting in the u	nderlying cause gwe	en in Part I.	23e. Did t		/	e cause of death?
Re he las	Completed						24a. Was autor perfo 1 Yes	an osy orined? 2V No	24b. Were autop prior to con death?	osy findings available inpletion of cause of
On of Vital Hedding Physicien: The lav h. Atter this certificate has funeral director, page 2	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 No H	ospital:	tient 2 ER/Outpatier	t 3□ DOA Othe	0.5	of Death Cock on your		☐Other (Specify	)
DIVISION OT VITAI  f or Attending Physicien: 1 after death. Director: After this certificat in by the funeral director. p.	Certification:	27. Manne of Death  1. Natural 5 Pending investigation  3 Suicide 6 Could not be	28a. Date of In (Month, D	lay Year) Injury	M 1□'	/at ⟨? Yes 2 ⊡N				19 N
UIVISION Hospitel or Attending 14 hours after death. Funerel Director: After lely filled in by the funer		4 Homicide determined	building, e	njury - At home, farm, str etc. (Specify) st of my knowledge, deatl		o data and	City or Tou	vn, State)	Number or Rural	
UNISIC  To the Hospitel or Attent within 24 hours after deall To the Funerel Director: completely filled in by the	Medical		er: On the basis and manner s	of examination and/or in stated.	vestigation, in my op	oinion, death number	occurred at the time,	date and p	signed (Month, L	the cause(s) Day, Year)
		30. Name and address of person who co	npleted cause of	death (Item 23a) (Type,	Print) //	828	magalis	Sep	Hmber	8,7006
11/2000	ate	31. Date filed (Month, Day, Year)	9W 32. Regis	StGGH No trar's Agnature	ad #30	2 /h	nnagolis	, m	10 21	401
Regist	4.50	SEP 1 1	2017	trar's Signature  ORIGIN	Sporte			21.0		

State of Maryland / Department of Health and Mental Hygiene 30163 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Patricia L. Anderson 2:28 PM 5, 2006 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day Year)
April 14, 1933 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□M 2X F Maryland 213-48-0911 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or itema 23a or 28a-f ehow vent, it e Medical Examinar must be notified at MD Baltimore White Hall 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2538 Openshaw Road 21161 U.S.A. Funera Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Š 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental Kate Lee Childress Claude S. Leffel, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy A. Jewell/Daughter 10986 Horsehoe Dr., Frederick, MD 21701 f Health 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its eny injury or of once. West Liberty United Methodist Cemetery Sept. 19, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State White Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc Michael Meur 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) netastatic Tonque Physician CANCER months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai attending to tor use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t Ö 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Rother (Specify) 1 Yes 2 No ို ŧ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Director; / 2 Accident 6 ☐ Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 125205 who completed cause of death (Item 23a) (Type, Print) N. Chales St. Balto. md 21204 6701 32. gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Mar		artment of rtificate of			Reg. No. ZUU {	, , , , , , , , , , , , , , , , , , , ,
	Physici /Medic	1	1. Decedent's Name (First, Middle, La Geneva Bouknigh	t				2. Date of Do Month 9-2-20	Day Year	3. Time of Death 6:00 A M
	Examin	er	4a. Facility Name (If not institution, given Prince George * s  5. Social Security Number 6. 8	Hospital	(In yrs. last birthday)	4b. City, Towr	$1$ , or Location of D $1$ y ar $oxedsymbol{eta}$ If Under 24		Prince Ge	orge's
าร์	Funeral Director		579-80-0685 Usual Residence of Decedent	1□M 2f2F 97	Yrs.	Months Day		Hrs. 8. Date of Bi (Month, D 6-16-1		thplace (State or Foreign ountry) berry SC
	he Marylan 28a-f show cuiffical at	Director	DC 10b. County DC	1	Washingt				10g. Citizen of What C	10d. Inside City Limits  XIXYes 2 □ No
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show say injury or other traumatic svent, the Medical Exactil at trival te notified at once.	by Funerai	1412 Morse St NE  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2\_No If Yes, Give Year or Dates:	er in U.S. 13.	20002 Was Decedent	of Hispanic Origin Juban, Mexican, P	? (Specify Yes or N verto Rican, etc.)	United Stat	es erican Indian, te, etc.
121215-0036	lled within 72 he fyglene. her then "netu nt, ine Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Lasi	College (1-4or 5+)	(Give	DO NOT use ret	ne during most of tired)		Private  Maiden Sumame)	Vindustry
Maryland	should be find Mental by marked of	To Be	Moses Williams  19a. Informant's Name/Relationship		19b. Maili	ng Address (Stre	Lena	Bell	per, City or Town, State,	Zip Code)
Baltimore, Ma	Pages 1 and 2 nent of Health a int: If item 27 la ury or other trai		Hattie Lake/Neice  20a Method of Disposition  11 Burial 2 Cremation 3 1 4 Donation 5 Other (Speci		20b. Place of Dispersion Commetery, cre Harmony	osition (Name of matory or other) Cemetery	olace) 7 9-8	Date 8-2006	n DC 20003 20c. Location - City or Landover M	
Balti	permit. Departr Imports sny inju		21. Signature of Funeral Service Lice	MX a	2	2. Name and Ad 617 Penr	dress of Facility ]	Pope Fune: Washingto	ral Home on DC 20020	
8760,	Physician (Medical Examiner per per per per per per per per per p	licai Examiner	23a. Part1. Enter the disease, or consolon, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cc.	consequence of):  b 1+1  consequence of):  consequence of):		Jing, soon as oa	out of respiratory of	arest,	Approximate Interval Between Onset and Death
P.O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify,			23d. Date of de Month	livery Day Year
Records, P.	The law requires that the ste has been signed by th page 2 should be detache	<u>م</u>	Part II. Other significant conditions Rend falur		not resulting in the t	ınderiying cause	given in Part I.		tobacco use contribute t	
al Rec	n: The law r licete has bu r, page 2 sh	Completed	PACEMAKEZ  GULY MATHUM  25. Was case referred to medical	blueding	-			1 Yes	opsy prior to death? 2.71No 1 □ Ye	utopsy findings available completion of cause of s 2000
Division of Vital	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	2 ER/Outpatie 28b. Time of Injury	of 28c. li	Other		one) sidence 6 Other (Spe how injury occurred	acify)
Divis	tal or Attains after dea	Certification:	3 Suicide 6 Could not learnined		y - At home, farm, st (Specify)	reet, factory, offi	се		(Street and Number or Rown, State)	tural Route Number,
	thin 24 hour this 24 hour the Funer	Medicai	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa  29b. Signature and title of certifier	hysician: To the best of miner: On the basis of e and manner state	xamination and/or in	ivestigation, in π	ny opinion, death (	occurred at the time	, date and place, and du	e to the cause(s)
)	F 3 F 8		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Tyng	DO (	043662	2	9/2/06	,
R	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar	ath (Item 23a) (Type	L DR (	Theresty	1 ND 20	785	

			1 - For Amend#1.Per P Registrar Amend#20b.Peri	State of M hys.PC 9-18 H PC 9-11-	arylan 3-06cr 06cr	d / Depa <i>Cei</i>	artment tificate	t of H	ealth a D <i>eath</i>	and M	lental Hy	giene Reg. No. 1	200	6 3	301	165
30	Physici /Medic	_	1. Decedent's Name (First, Middle, Las Jessie Beard	-	Jess	se I	3earc	3			2. Date of Dea Month 09/	Day	2006		ime of E	Death ам
, ,	Examin		4a. Facility Name (If not institution, give						Location o				ounty of De			
		1	1906 Rochelle				Dis		ot He				ince		rge	
	Funeral Director		5. Social Security Number 6. Security Number 11	ax D¥M 2□F	70 (In yrs. 1	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 05/18/	Year)	6 Vi	irthplace ( Country) rgir		roreign
	*		Usuat Residence of Decedent								03/10/	193	0 1	1911.	ша	
	how		10a. State 10b. County		1	, Town or Lo									side City	
	Ba-f	cto	MD P.G.		DIS	stric	с не:	ıgnt	S						Yes :	2   No
	with th	Dire	10e. Street and Number 1906 Rochelle	Ave. #16	200		10f. Zip		,				en of What (	Country?		
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. I Health and Menial Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Madical Examination and the modified at	Funeral Director	11. Marital Status			S 13.1		0743		gin? (Spe	acify Yes or No		S.A. 4. Race - An	nerican Inc	dian.	
(0	r itan	Fun	1 Never Married 2 Married	12. Was Decedent Armed Forces: 1  Yes 2 If Yes, Give	No					, Puerto	ecify Yes or No Rican, etc.)		Black, Wh	rite, etc.		
93	rai', o	ğ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		-	1 ☐ Yes 2	2LX-No	Specify:				Specify: B	таск		
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece (Give	kind of wor	rk done d	turina most	t of worki	ng	16b. Kin	d of Busines	s/industry		
121	Mithin han	d L	Elementary/Secondary (0-12) 5th	College (1-4or	5+)		oo NOT us ck Di					Pr	ivate			
CA	filed v Hygie other t		17. Father's Name (First, Middle, Last)			TIU	- N DI	TAG		r's Name	(First, Middle,					
an	ould be Mental Marked o	To Be	Charlie Beard						AnnL	ee	Moore					
Maryland	2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the Ma	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address				il Route Numbe	er, City or	Town, State	, Zip Code	)	
	1 and 2 Health a am 27 is		Larry Beard /	Son	-	1473	Unio	on S	t.Cl	ear	water,	Fl.	2074	3		
ore	of Hea of Hea fitam rothe		20a. Method of Disposition  **Surial 2   Cremation 3	Removal from State	C	lace of Dispo emetery, crer	natory or o	ther place	θ)		Date		ation - City o		tate	
Ë	Pag ment ant: f		4 Donation 5 Other (Specify			Linco					4/06			•		
Baltimore,	permit. Pages 'Department of himportant: if its any injury or of once.		21. Signature of Funeral Pervice Licen	Tarlo	7	11	722 N	√.Ca	pito	ol S	ylor's t.NW W	ash	neral Ingto	Hom n,DC	e 20	001
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each I	d the death	n. Do not ent	er the mod	e of dyin	g, such as	cardiac o	or respiratory ai	rrest,		Inter	oximate val Betweet and De	een
	Physician		Immediate Cause (Final disease or condition	. Car	dio	vasc	lar	0	isea	150	-			Onse	and De	aatn
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):	_									
1,	s 🥞	i.	Sequentiatly list conditions,	b. Due to (or as	I A K	DETC										
	nted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											1		
Ć,	sate be executed they sicien and the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):										
8760,	ysicie	cai		d.												
9	Physicism: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE:											1		
Вох	ath ce	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetat	death 3	Ectopic pr					2	3d. Date of d Month	lelivery Day	Ύє	ear
	the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	eath 5∟	Other (sp	ecify)						,		
P.0	res that the de signed by the e be detached i		Part II. Other significant conditions of	ontributing to death t	out not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco us	e contribute	to the cau	se of de	ath?
sp.	uires sign lid be	Completed by	Hypertensio	N							10,	Yes 2	¥6 3□	Probably	4 🗍 Ur	ıknown
000	w requir s been si should!	jete	Scizurediso	1der							24a. Was		24b. Were	autopsy fir	ndings a	vailable
æ	The lay	Eo	multiple	stroke	25							ormed?	death	comptetion	on or call	JSB OT
ital	ysician: The is certificate hidirector, page	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
of Vital Records,	Physic this ce al dire	၉	1 Yes 2 No			ER/Outpatier			4 🗆 140		me 5 <b>∑</b> Resi			oecify)		
n o	ding P	inol	27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury		8c. Injun			28d. Describe I	how injury	occurred			
Division	Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be		iun, - At ho	ome farm str	M factor		Yes 2 1		28f. Location (	Street and	Number or	Rural Rout	te Numb	
Ď	i or A after Direct	ertif	4 Homicide determined		tc. (Specify		eet, factory	, onice			City or Tox		TVOMOGI OF	10/4/ /100		or,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best	of my kno	wledge, deat	n occurred	at the tim	ne, date an	d place,	and due to the	cause(s)	and manner	as stated.		
	n 24   n 24   he Fu	edical	(Check only 2 Medical Exam	niner: On the basis of and manner s	of examinat	tion and/or in	vestigation,	, in my op	oinion, dea	th occurr	ed at the time,	date and	place, and d	ue to the c	ause(s)	
	To the To the COME	Ž	29b. Signature and title of certifier	240	/	2			number				signed (Mo			
1	7		Metho	1/ thisak	en		1	100	302	76		9.	-11-0	06		
1	(2)		30. Name and address of person who			1 23a) (Type,	Print)		0 1	140	WAY	C	.+1-	10	10	7.710
1	21		DEBORAH M. 31. Date filed (Month, Day, Year)	THO MY	rar's Signa	IVI)		> 1 C	) M	UIK	W/K /	<u>)</u> c	11101	~ 10	W	21/16
	Sta Regist		SEP 1 1 2006	Med	K	host	25									

DHMH 17 Rev 1/2001

			1- State of Maryland Registrar		irtment of He tificate of D			a No.	30166
	Physicia		Decedent's Name (First, Middle, Last)  JAMES  BENN	ETT			2. Date of Death Month SEPTEMB1	Day Year ER 06, 200	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
Ε			3211 LASSIE AVENUE		SUIT				GEORGES
	Funeral Director		5. Social Security Number 251-42-4861 6. Sex 1X M 2□F 7. Age (In yrs. last 76)	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01-04-19		rthplace (State or Foreign Country) TH CAROLINA
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Loc	cation		<u> </u>		10d. Inside City Limits
	Mary B-f sho	tor	MD PRINCE GEORGE'S CO. SU	ITLAN	D				TX Yes 2 □ No
	ith the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23a	rai	3211 LASSIE AVE.	10.1	20746	0.1.1.0.4	7	USA	
20	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiens. I firem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Exam natural be notified a	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spenic Origin? Mexican, Puerto Specify:	Rican, etc.)	14. Race - Am Black, Wh Specify: B]	ite, etc.
5	2 hou	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupa kind of work done d	tion	1	6b. Kind of Busines:	s/Industry
7	ithin 7 ne.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. E	DO NOT use retired)	uning most or worki	ng		
7	2 should be filled withir and Mental Hygiene. Is marked other than aumatic evant, the Ma		12 TH  17. Father's Name (First, Middle, Last)	CREW (		18. Mother's Name		NSSC	
<u> </u>	d be f ental h ced of c eval	o Be	CLAYTON BENNETT			WILLIE MA		alder Domane,	
<u> </u>	should and Men s marke umatic	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin				City or Town, State,	Zip Code)
Ĭ.	and 2 alth a 127 ls		STEVEN BENNETT/SON	1424	INDEPEND	ENCE AVE.	SE WASI	HINGTON, I	C 20003
	permit. Pages 1 and 2 Department of Health s Important; If itam 27 li any injury or othar tra once.		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	netery, crem	sition (Name of natory or other place EMORIAL	9)		Oc. Location - City o	
Dallillo	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	W 22	Name and Address MARSHALL 4308 SUI		L HOME (	OF MARYLAN LAND, MD 2	ID, INC. 20746
П			23a Part . Enter the disease, or complications that caused the death.	Do not ente					Approximate Interval Between
_1	Pnysician		Immediate Cause (Final disease or condition	ARRHY	THMIAS				Onset and Death
	/Medical Examiner		Due to (or as a conseque	ence of):		TIUDE			
		e	Sequentially list conditions, if any, leading to immediate b.		HEART FA	TLUKE			1
	uted d ansit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ATED	CARDIOMYO	PATHY			
ĵ.	an an		resulting in death) Last Due to (or as a conseque	nce of):					
0/00,	ificate be executed g physician and as the burial-transit	edicai	d						
0 X 0	ding p		IF FEMALE: 23c. If yes, outcome of pregnance	cv				23d. Date of de	lives.
0	The law requires that the death cert tie has been signed by the attendingage 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	leath 3 🗌	Ectopic pregnancy Other (specify)			Month	Day Year
ŗ	res that the de signed by the a i be detached f		Part II. Other significant conditions contributing to death but not result	ing in the un	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute i	to the cause of death?
cords,	w requires been sign should be	ed by	CORONARY ARTERY DISEASE				1 ☐ Yes	s 2□No <b>XX</b> F	robably 4 🗍 Unknown
osau	he law re s has bee ige 2 sho	Completed	PERIPHERAL VASCULAR DISEASE				24a. Was an autopsy perform	prior to death?	
		a	25. Was case referred to medical			26. Place of Death			s 2 No
	Physici this cer al direc	To B	examiner?  **XXYes 2 \[ \text{No} \]  Hospital: 1 \[ \text{Inpatient} 2 \[ \text{El} \]	R/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursing Ho	me XX Resider	nce 6 Other (Spe	ecify)
	ding Physician: The la h, After this certificate has funeral director, page 2		27. Manner of Death  XXNatural 5 □ Pending  28a. Date of Injury (Month, Day Year)  2	28b. Time of Injury	Work	?	28d. Describe hov	w injury occurred	
2	vttandii death, ctor: A y the fu	cati	2 Accident investigation			′es 2□No	296 Lacation (Cta	ant and Number of C	Pure I Courte Number
	l or At after o Direc	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, rarm, stre	eet, ractory, office		City or Town,	eet and Number or F State)	urai Houte Number,
-	To the Hospital or Attanding Physician: Whith 24 hours after death To thin Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one)  Will Certifying Physician: To the best of my knowl one one of examination and manner stated.	edge, death	occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within To the Somple	Me	29b. Signature and title of certifier		29c. License	number		d. Date signed (Mon	th, Day, Year)
	200		I / week trus to	my.	D 3348	3	0	9/07/2006	
	1/10		30. Name and address of person who completed cause of death (Item 2						
	(30)		PRADEEP SRIVASTAVA, MD. 7227 B		ER PKWY.	GREENBEL'	r, MD 20	770	
	Sta Registr		SEP 1 1 2006 Security September 2006						

December State   Processing   Company   Comp				For State Registrar		State of M	larylan	d / Depa <i>Ce</i>	artment of H <i>rtificate of I</i>	lealth and Death	d Mer		giene Reg. No.		3016	7
Comment   Comm		Dharaisi		1. Decedent's Name	e (First, Middle, Las	st)					2.			/ Year	3. Time of Death	
4. Facility but and of not sumblishing was smell and numbers   4. Country of Cases   1500 OCT STREET   1500 OCT STREET   5. Should independ a property of the				LOLA					BURDICK		S		-		3:30 A M	
Second Second Primaries   Second Second Primaries   Second Second Primaries   Second Pr				4a. Facility Name (/	f not institution, give	e street and number	)		4b. City, Town, or	Location of De	eath		4c.	County of Deat	h	
Contract   Contract																
Description   Description	H				1						fin. 8.	Date of Birtl	h /, Year)	9. Birt	hplace (State or Foreigr	7
Description   Description		Director			06		91	115.	l		JU	JLY 13	, I	ATO MASS	SACHUSEIIS	_
Comparing the property of th		land					10c. City	r, Town or Le	ocation						10d. Inside City Limits	
Comparing the property of th		Mary	ţō	MARYT.AND	MONT	COMERY			POOLS	VILLE					1 ☐ Yes 2€ No	
Comparing the property of th		28a	rec			COLLEGE							10g. Citi	izen of What Co	untry?	_
Comparing the property of th		3a o	Die	19609 GOT	T STREET					20837				U.S.	.A.	
Comparing the property of th		deatl	ner	11. Marital Status		12. Was Deceden	t Ever in U.	S. 13.	Was Decedent of H	ispanic Origin?	(Specify	Yes or No-				
Comparing the property of th	036	ours after rai', or ite Examina	by Fui		_	If Yes, Give					лы олы	an, etc.)		1.71		
Comparing the property of th	5-0	72 ho natu	etec	(Spec	15. Decedent's Ed	ducation de completed)		16a. Dece	dent's Usual Occup	ation during most of	working		16b. Ki	ind of Business/	Industry	
Physician / Medical Examiner  23a Part State the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and Death of the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and of death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate an examination and/or investigation in resulting in death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriately appropriate and past cardiacy respiratory arrest. Appropriately appropriately appropriately and past cardiacy respiratory arrest. Appropriately a	7	ithin Ber	npi	Elementary/Seco	ndary (0-12)		5+)			1)				HVADTI	ED II	
Physician / Medical Examiner  23a Part State the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and Death of the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and of death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate an examination and/or investigation in resulting in death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriately appropriate and past cardiacy respiratory arrest. Appropriately appropriately appropriately and past cardiacy respiratory arrest. Appropriately a		led w lygier lyer th	õ					<u> </u>	ECRETERY	40.14.15.4.1						_
Physician / Medical Examiner  23a Part State the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and Death of the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and of death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate an examination and/or investigation in resulting in death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriately appropriate and past cardiacy respiratory arrest. Appropriately appropriately appropriately and past cardiacy respiratory arrest. Appropriately a	and and	be fi	Be											Sumame)		
Physician / Medical Examiner  23a Part State the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and Death of the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and of death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate an examination and/or investigation in resulting in death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriately appropriate and past cardiacy respiratory arrest. Appropriately appropriately appropriately and past cardiacy respiratory arrest. Appropriately a	3	nould I Mer narke	10			T 0-i		105 11:33						· F O	T. 0. 4.1	
Physician / Medical Examiner  23a Part State the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and Death of the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and of death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate an examination and/or investigation in resulting in death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriately appropriate and past cardiacy respiratory arrest. Appropriately appropriately appropriately and past cardiacy respiratory arrest. Appropriately a		and 2 sl salth and n 27 is r						1960	9 GOTT ST	REET, I	POOLS	SVILLE	, M	ARYLAND		
Physician / Medical Examiner  23a Part State the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and Death of the cause of death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appropriate an examination and of death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate an examination and/or investigation in resulting in death. Do not enter the mode of dying, such as cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriate and past cardiacy respiratory arrest. Appropriately appropriate and past cardiacy respiratory arrest. Appropriately appropriately appropriately and past cardiacy respiratory arrest. Appropriately a	imore	Pages 1 ment of He ant: if iter		1 🗆 Burial 2	Cremation 3 🖸		_   06	emetery, cre	matory or other plac	о) UM 09/				-		A
Physician Modical Examiner  Physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Examiner  Part   The physician Modical Modical Examiner  Part   The physician Modical Modical Examiner  Part   The physician Modical Mod	Balt	permit. Departr Importr eny in		21. Signature of Fu	ineral Service Licer	ns <del>ee</del>		EÎ	WARD <sup>and</sup> Addi 191 ROCKVI	Lof FUNE LLE PI	RAL I	DIRECT ROCKVI	CION	, INC.	AND 20852	
Interesting Cause (Final cause) (Final cause				23a. Part 1. Inter to shock or hea	he disease, or com	plications that cause one cause on each	ed the death				20170				Approximate	
Due to (or as a consequence of):    Principles   Principl	٠Ē	Physician		Immediate Cause	(Final			AD	ENO GARCI	nonA	70	LIV	ER			
Sequentially list conditions of property of the conditions of the	4					Due to (or a	s a consequ	uence of):								
The complete of the complete o		Examiner		Seguentially list co	nditions	D			NOWN							
The complete of the complete o		ם יו	iner	if any, leading to in cause. Enter Unde	nmediate orlying	Due to (or a	s a consequ	ence of):								
FEMALE:   23b. Was decedent pregnant		ecute and trans	cam	that initiated events		c										
DODA TO THE PROPERTY OF THE PR	760,	e be ex rsician e burial	cal E	,	l	d	s a consequ	derice (ii).								
DODA TO THE PROPERTY OF THE PR		tificat ig phy as th	ledi													_
DODA TO THE PROPERTY OF THE PR		he death cer / the attendir ched for use	ysician/N	23b. Was deceden in the past 12 1 ☐ Yes 2 ₽	months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	death 3[							•	
DODA TO THE PROPERTY OF THE PR		that I		Part II. Other signif	ficant conditions of	ontributing to death	but not resu	ulting in the u	inderlying cause giv	en in Part I.		23e. Did to	bacco u	ise contribute to	the cause of death?	
25. Was case referred to medical examiner?	rds	quires n sigr uld be	d b									1 🗆 Y	es 2	ÅNo 3□Pr	obably 4 Unknown	
25. Was case referred to medical examiner?	S	w rec	iete									24a. Was a	an	24b. Were au	Itopsy findings available	
25. Was case referred to medical examiner?	æ	The fa	E								-	perfor	med?	death?		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGORAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MAY LAND 20832	ta	en: T tificat tor, p	a	25. Was case refer	red to medical					26 Place of I	Death (C			1 Tes	2 L No	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGORAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MAY LAND 20832	<u>&gt;</u>	ysici is cer direct	0.0		No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatie	nt 3□ DOA Oth					6 □Other (Spe	cifv)	_
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGORAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MAY LAND 20832	0	g Ph				28a. Date of In	jury	28b. Time o								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGORAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MAY LAND 20832	10	ath. Pr: Aff	atlo		investigation	1	ay / (21/)	injury								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGORAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MAY LAND 20832	)ivis	or Atterde	rtiffe		6 Could not be determined	280. Place of II	njury - At ho etc. <i>(Specif</i> y	me, farm, st	reet, factory, office		28f.				ıral Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGORAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MAY LAND 20832	u	spital		29a. Certifier	1⊠ Certifying Ph	ysician: To the bes	t of my know	wledge, deal	th occurred at the time	ne, date and pl	ace, and	due to the o	cause(s)	and manner as	stated.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGORAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MAY LAND 20832		the Ho in 24 the the Full pletely	edic	one)	2 Medical Exam	niner: On the basis	of examinat	tion and/or in	ovestigation, in my o	pinion, death o	ccurred	at the time, o	date and	place, and due	to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHITRA RATAGOPAL 18111, PRINCE PHILIP DRIVE, #327, OLNEY, MARY CAND 20832		with To 1	2	1/1		0					>					
18111, PRINCE PHILIP DRIVE, # 327, OLNEY, MARYLAND 20832		<(1)							240	x 4) c		`	75 1	18MBG	27,2006	
				18111, P	RING 1	PHILIP Z	NIVE	# 3	27, OL1	VEY, 1	RI MAR	9 JAG	OPA	0832		

## Please Type or Print in Black Indelible Ink

		l- For State Registrar		Certificate of			Reg	No 20	06 3016
Physicia dical Examii	ner	1. Decedent's Name (First, Middle, L	ELL RANDOLE				Date of Death Month September	Day Year 14, 2006	1500 hrs
		4a. Facility Name (if not institution, 7208 Riverdale Road	give street and number)		b. City, Town, or L Hyattsville	ocation of Death		4c. County of Dear	
Funeral Director		577-68-3087	Sex 7. Age (In y X) 7. Age (In y 56	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	7	(MM/DD/YYYY) 9 Bi Fore 2,1949	
yland -f show any once.	_	Usual Residence of Decedent  10a State 10b. County  MD • PRINCE	GEORGES 10c. C	City, Town or Location	ATTSVILL				10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	I Director	10e Street and Number 5009 59th	AVE.		10f. Zip Code	•	10	g. Citizen of What Cou	intry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene teath and Mental Hygiene teat 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at once transmatic event, the Medical Examiner.	by Funeral	11. Marital Status 1 Never Married 2 XMarr 3 Widowed 4 Divord	12. Was Decedent Ever in Armed Forces?  1 X Yes 2 N  1 Yes, Give Yea 1 969-1	If Ye	s Decedent of Hispes, specify Cuban, Yes 2 X No	Mexican, Puerto		White, etc.	rican Indian, Black,
0036 within 72 hours giene rer than "natura Medical Exanti	eted	15. Decedent's Education (Specify Elementary/Secondary (0-12)		d) 16a. Decedent during mo	s Usual Occupations of working life	DO NOT use retii		16b Kind of Business SELF EMPL(	Industry
21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica	Comple	17. Father's Name (First, Middle, La	ast)	I HOI			(First, Middle, M		DIED
ore, MD 2121 es I and 2 should be f of Health and Mental If item 27 is marker her traumatic event,	o Be	PAL 19a Informant's Name/Relationship	BARBER (Type, Print )	19b. Mailing	Address (Street		LLIAN Rural Route Numb	MARSH per, City or Town, Stat	e, Zip Code)
i, MD 2 and 2 shou lealth and N tem 27 is n traumatic		CAMILLA WHITE 20a Method of Disposition	/ SISTER					A. 22556	
Baltimore, MD permit Pages I and 2 shu Department of Health and Important: If item 27 is injury or other tranmat		1 X Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State cify:	0b. Place of Disposi crematory or oth	er place) VETERANS	CEM. 9-		20c. Location - City o	AM, MD.
Bal permin Depar Impo		21. Signature of Funeral Service Lie	201.211.61	Снд 400091   580	ame and Address AMBERS FU D1 CLEVEI	NERAL H LAND AVE	OME & CR	REMATORIUM,	P.A. 20737
Physician /Medical ¬xaminer		23a Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate		oin) intoxio		uch as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
executed an and al - transit	I Examiner	Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence						
an an	Medical	X UNPENDED		23a,27,28a-f	f,perME,g86	0,10/3/06	TT	Lood Bar Car	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c If yes, outcome of p  1 Live birth 4 Pregnant at time c	2 Fet	al death 3 ener (Specify)	Ectopic pregna	ncy	23d Date of deliver Month	y Day Year
ires that the de signed by the	d by Phys	Part II. Other significant condition	tana di di di di di di di di di di di di di	not resulting in the u	nderlying cause gi	ven in Part I	23e. Did tob	pacco use contribute to	the cause of death?
Records, The law requir icate has been s	Completed						24a Was ar autops perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of
Vital Reysician: The his certificate director, page	o Be (	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		of Death (Check of Death (Chec		tesidence 6 🗸 Othe	r: Scene
on of V rending Phy eath or: After th	- t	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident Investig	28a. Date of Injury (Month, Day, Year)  Fnd 9/14/200	28b. Time of Ir	njury 28c Injury	at Work?		ow Injury occurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 X Could r 4 Homicide	not be ined (Specify) Hot	use			Hyattsvi	11e, MD River	
To the Hospital within 24 hours Fo the Funeral	Medical	(Check only   Certifying Phys	sician: To the best of my know ner: On the basis of examination and manner stated						
	M	29b. Signature and title of certifier	lever		29c License O.C.N			29d Date signed (Mo	
-		30. Name and address of person will Laron Locke MD. Ass	ho completed cause of death ( sistant Medical Examin		Street, Baltim	ore, MD 212	01		
									1

			1 - For State Registrar	State of Marylar		artment of F rtificate of			ene 200	6 30169
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  5 TUAR T	D		BAYO	-22	2. Date of Death Month	81 2	3. Time of Death
	Examir	ier	4a. Facility Name (If not institution, give s Anne Arundel Med:	ical Center			r Location of Death Mapolis	1	4c. County of D	e Arundel
	Funeral Director		5. Social Security Number 6. Sex 083-28-8083	7. Age (In yrs. 70	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Apr. 3,	<sup>(ear)</sup> 1936	Birthplace (State or Foreign Country) NY
	Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne Anne		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	with the	Direc	10e. Street and Number  233 South River (	Clubhouse		10f. Zip Code	)776	109	g. Citizen of What	,
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itams 23e or 28e-f show event, tre Medical Everther must be notified at	by Funeral Director		12. Was Decedent Ever in L Armed Forces? 1 XYes 2 □ No 1	954-	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc. Vhite
2121	filed within 72 ha Hygiene. other than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 12	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired ales Mana	during most of wor f)	king 16	Self Em	,
Maryland	should be filed nd Mental Hygi marked other umatic event, I	To Be (	17. Father's Name (First, Middle, Last) David Bayer					ne (First, Middle, Ma Schwartz		
	nd 2 alth a 27 ts r trau		19a. Informant's Name/Relationship (Type Jodi Kubisiak/Daug					ral Route Number, ( Ouse, Har		
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	sition (Name of natory or other place Crematory	Ser	) 6	oc. Location - City Baltimore	
Balti	permit. Pag Department Important: I any njury o pncs.		21. Signature of Funeral Service License	Aller-	B 4	Name and Address Arranco 8 95 Gov. R	Sons, Parity Pitchie H	.A. Sever	na Park na Park.	Funeral Home MD 21146
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the deal e cause on each line.	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	icate be executed by sician and by sician and si the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	emi	o circli	el inf cular	Drien	9~ 1	z n yean
. Box	death certif e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ecords, P	law requires that the de as been signed by the a 2 should be detached	۾	Part II. Other significant conditions cont	inbuting to death but not res	sulting in the ur	nderlying cause give	en in Part I.			lo the cause of death? Probably 4 DUnknown
Ï	The lay	Completed	Renal fai	lun, ac	ute	+ chy	our.	24a. Was an autopsy performe	prior t	
	siclan certifi rector	o Be	25. Was case referred to medical examiner?	ospital:		Dthe	ar.	th (Check only one)		
0	g Phy er this eral d	$\vdash$	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury Work	4   Nursing H	ome 5 Residence 28d. Describe how		pecify)
200	endin sath. or: Aft he fun	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		r? Yes 2 □ No			
Division	To the Hospital or Attending Physician: within 24 hours aller death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	he Hospi in 24 hou he Funer pletely fil	edical	29a. Certifier (Circle only one) 1 Certifying Physical Examine	ician: To the best of my known:  On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
ì	To T CO.	Σ	29b Signature and title of certifier	Hen	Agu	29c. License	number 2 1 4	38	Date signed (Mo	nth, Day, Year)
	5+1		30. Name and address of person the con	peted cause of death (Item	1 23a) (Type, I	DEFEN	SEH16	HWAY A	NNAPOL	5 M 121401
- 6	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	land.				***************************************

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Maurice Lee Boone September 6, 2006 12:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Aug. 15, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 82 Director 1924 220-26-5372 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examinar must be rediffed at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 No Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5295 Fleming Road 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ₩ Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Foreman Construction other traumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth eny liviny or other traumatic event ADEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Steven Arthur Boone Laura (unobtainable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Boone / Son 5295 Fleming Rd. Mt. Airy, MD 21771 20b. Place of Disposition (Name of cometage competition of other place)
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Sept. 9, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Frederick, Maryland 21. Signature of Farieral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Squartially flat conflictions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequer Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 16 2 ER/Outpatient 3 DOA Certification: To 1 patient 27. Manne f Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 atural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) 39502 9/6/06 use of death (Item 23a) (Type, Print) East Main Street Westwinster MA tto egistrar's Signature 31. Date filed (Month State Registrar

Division of Vital Records, P.O.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 6 **Physician** 2006 Thomas Baisey, Jr. 6:18PM /Medical 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min December 20, 7. Age (In yrs. last birthday). 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1926 North Carolina **1**√2 M 2□ F 577-30-7932 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f ehow as 1 and 2 should be filed within 72 hours after death with the Marylar of Heelih and Mental Hygiene. I here 23s or 28s-1 ehow item 2.7 is marked other then "naturel", or Items 23s or 28s-1 ehow then 72 is marked other then "naturel", or other traumatic event, the Medical Examine must be notified at Frederick Frederick 1¥ Yes 2 No Maryland Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21702 2509 Shelley Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 4<sup>College (1-4or 5+)</sup> Elementary/Secondary (0-12) NSA Analyst permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked othe eny Injury or other traumatic event, gange. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peachey Ancarrow Thomas G. Baisey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Shelley Circle, Frederick, Maryland 21702 Ruth Baisey - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 対 8urial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland Resthaven Memorial 9-11-2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Luce 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mos /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and the deteched for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has I tuneral director, page 2 s autopsy performes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only of Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours effer death.

neral Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ec. License number an D-13971 nu of death (Item 23a) (Type, Print) 30. Name and address of person who complete W. Ninth Street, Frederick, Maryland 21701 Robert L. Kaufman agistrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 30172 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SEPTEMBER 2006 10. 5:55 P EVELYN LESTER BAILEY /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES INDIAN HEAD 103 JENNIFER DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MARCH 10, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F ALABAMA Yrs. Director 423-20-8989 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "neturel", or iteme 23a or 28e-f ehow traumatic event, the Mudical Expreiner must be motified at 1√EYes 2 No Directo MARYLAND CHARLES INDIAN HEAD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 20640 103 JENNIFER DRIVE 12. Was Decedent Ever in U.S.
Armed Forces?
10 Yes 2 No 1944—
If Yes, Give 1046 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2) No Specify: If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 end 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE ADMINISTRATIVE FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) REBA LESTER JESSE CARL LESTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA BAILEY TROTT/DAUGHTER 103 JENNIFER DRIVE, INDIAN HEAD, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny injury or oti 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal Irom State THE HUNTT CREMATORY SEPTEMBER 11,2006 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 
LIDIA C. THORNTON JOHNSON 200583 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EREBROVASCULAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin ng physicien and as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔊 No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HOLESTENOL 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? To the Hospital or Attending PI within 24 hours efter death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w

DHMH 17 Rev 1/2001

State Registrar

Louis Kaufman

31. Date filed (Month,

MD

1 2006 32. Redistrar's Signature

12070 01d Line Centre, #207 Waldorf, Maryland 20602

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2 0 0 0

			1 - For State Registrar	State of Mar	yland / Dep Ce	ertificate of	Death	Re	g. No.	6 3017
	Physici /Media		1. Decedent's Name (First, Middle, La  John Fran		amin			2. Date of Death Month Septemb	Day Yea er 3, 200	
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Deat	h	4c. County of De	ath
			659 Alabama Aver	iue		Rose I			Anne Ar	rundel
	Funeral Director		201-00-1/9/	GW OFF	In yrs. last birthday	Months Days	ff Under 24 Hrs Hours Min.		<sup>year)</sup> 1943 F1	irthplace (State or Foreign Country) Orida
	death with the Maryland me 23a or 28a-f show Fullst be notified at	-	Usual Residence of Decedent  10a. State  10b. County		Oc. City, Town or t					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he N 18a-f	Director	MD Anne Art	indel		Rose I	laven			**
	di o		10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
	e 23	eral	659 Alabama Aver	1UE 12. Was Decedent Eve	es in U.C. 42	207			USA	
000	be filed within 72 hours after death with the Marylan ital Hygiene.  do other then "naturel, or iteme 23a or 28a-f show event, the Medical Examilier uses be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1 ☑		. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecry Yes or No- to Rican, etc.)	Black, Wh	
200	hou		15. Decedent's E			edent's Usual Occu	nation	11	6b. Kind of Busines	hite
2	in 72 na r	Completed	(Specify only highest gra	ade completed)	(Giv	e kind of work done  DO NOT use retire	during most of wo	rking	ob. Kind of Busines	symoustry
7	iene	E	Elementary/Secondary (0-12)	College (1-4or 5+)	elec	tronic er	ngineer		electroni	CS
3	e filed within al Hygiene. i other then "	BeC	17. Father's Name (First, Middle, Last	)	0200	0201120 01		ne (First, Middle, Ma		.05
2	2 should be and Mental Is marked o	To B	Edward Gregory	Benjamin			Fannie	Lane		Emmons
¥	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke eny injury or other treumatic.	1-	19a. Informant's Name/Relationship (			ling Address (Stree		ıral Route Number, i	City or Town, State	
Ž	and 2 ealth a n 27 ls		Jacqueline Z. Ber	iamin. spou				ose Haven		
נֿע	Heart term		20a. Method of Disposition		20b. Place of Disp	osition (Name of		-	Oc. Location - City of	
2	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		*	ematory or other pla	1			
	artme ortan injur		21. Signature of Engral Service Lices			1tan Crer 22. Name and Addre		-09-06 A	1exandria	i, VA
מ	Depa Impo eny ii		1 William	RGio		Rausch Fu	neral Ho	me, P.A.,		MD 20736
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c	onsequence of):	iail ceil hun	Cionac			4 marths
	Examiner									
		Jer	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of).					
	outed of ansit	Examiner	that initiated events	C						
ົ	exection and and and and and and and and and an	Exa	resulting in death) Last	Due to (or as a c	onsequence of):					
	te be ysicie ie bu	edical		d						
9	tifical g phy as th	ed								
5	h cerl endin use	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Terrorio organia			23d. Date of d	elivery
	the ett hed for	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Uлклоwn	4☐Pregnant at tim 9☐ Unknown		□Ectopic pregnand □ Other (specify) _	У		Month	Day Year
	that the ed by detacl		Part fl. Other significant conditions of	ontributing to death but r	not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute	to the cause of death?
cords,	Physicien: The law requires that the death certificate be executed this certificate hes been signed by the ettending physicien and all director, page 2 should be detached for use as the burial-transit	Completed by						1 Pres	2 □ No 3 □ F	Probably 4 Unknown
ָ ֪֞֝	awre s be	plet	/					24a. Was an	24b. Were a	autopsy findings available
	The I	E						autopsy	death?	
5	en:	0	25. Was case referred to medical				26 Place of Dea	1 Yes 2		s 2 No
>	ysici s cer direc	0.0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatie	nt 3 DOA		ome 5 X Residen		100.6.1
5	er thi	-	27. Manner of Death	28a. Date of Injury (Month, Day Ye				28d. Describe how		ecily)
5	ath.	e te	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ear) Injury		rk? ]Yes 2 ∐No			
2	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director. Attent his certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, s Specify)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
_	spital nours a nerel [		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of m	ny knowledge, dea	th occurred at the ti	me, date and place	, and due to the cau	se(s) and manner a	as stated
	the Ho in 24 t the Fu tpletely	Medical	one)	niner: On the basis of ex and manner stated	amination and/or ii	nvestigation, in my	opinion, death occu	rred at the time, date	and place, and du	e to the cause(s)
	To To To	2	29b. Signature and title of certifier			29c. Licens		290	I. Date signed (Mor	nth, Day, Year)
			cell			0)	56024		September	5 2006
ı	2+1		30. Name and address of person who Kenneth L. Helson 31. Date filed (Month, Day, Year)	completed cause of death	h (Item 23a) (Type	Seete 110	Prince Fr	edende vil)	20678	
Ú	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	Signature	1 .				
	Registr		SEP	7 2006	au K	Coerte	,			

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2006 30174 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) September 16, 2006 **Physician** a.k.a. Lilia Marie Brody 6:00a M Lillian Marie Brody /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 1604 West Seventh Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | North | Dec 15,1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2XX¥ Months 82 Pennsylvania 188-18-2531 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State raf, or items 23a or 28a-f show Examiner must be notified at Monrovia Maryland Frederick 1 ☐ Yes 2 XNo Completed by Funeral Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 21770 4195 Windy Hill Drive Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hyglene.
ann: It leam 27 is marked other than "neturef", or Items 23a ury or other traumatic event, its Medical Estim or mutury or other traumatic event, its Medical Estim or mutury. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No 3₺Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sgarrella Gillotti Annette Rosa Dominic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4195 Windy Hill Drive, Monrovia Maryland 21770 19a. Informant's Name/Relationship (Type, Print) Linda Brody Walburn, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemty | Sep 19, 2006 Silver Spring, MD permit. Pag Department Important: I eny injury o 4 □ Donafion 5 □ Other (Specify) 21. Signatur of Fune al Service L Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 MO0706 23a. Part 1. Enter the dilease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Immediate Cause (Final disease or condition ance Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a deteched f 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ Yes 2 No 3 Probably 4 Unknown cete has been si, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 1 Tyes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospitat: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification; 1 Natural after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after To the Hospital o within 24 hours at To the Funeral D Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D46096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hope A. McIntyre, M.D., 1502 S Main Street, #202, Mount Airy, Maryland 21771-5363 32. Restrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 2 2006 Registrar

Cable Worker  Cable Division, Inc.  Cable Worker  Cable Division, Inc.  18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 17. Father's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  19. Marcia Gloria Escobar/Sister-in-  Mort Cable Division, Inc.  19. May 18. Mother's Name (First, Mossie, Masen Summary  19. Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. May 18. Mother's Name (First, Mossie, Masen Summary  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19. Marcia Gloria Escobar/Sister-in-  19.			•	For Stete Registrar	State of Mar	yland / De	epartment of H Certificate of I	lealth and M Death	fental Hyg R	iene <sub>eg. No.</sub> 2 (	06	30175
The complete of the control of the c		Physici	an	11	,						Year	
POLICIO DE LA CONTRETA DE LA CONTRET		/Medic	al				4h City Town or	Location of Death	9			1576 PM
Supplied Control Processor   Supplied Control		Examin		the state of the state of	_	· Couter	0 115			- 4	•	City
Discrete   Discrete		Funeral			Sex 7. Age	(In yrs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day	)	9. Birthr	place State or Foreign
102. Call   103. States   105. Child   105	Н	Director			MEIM ZUP	23 Yrs	s				E1 S	alvador
Compared to the control of the con		yland				10c. City, Town o	r Location					
Compared to the control of the con		Ba-fal	ctor	, , , , , , , , , , , , , , , , , , , ,	ery	Mont		age				
Compared to the control of the con		with th			Circle #102			1886	1			
Compared to the control of the con		ms 23	nera		12. Was Decedent Ev		13. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Ra	ace - Americ	can Indian,
Compared to the control of the con	036	urs after	by	•	1 ☐ Yes 2 No			-				
The state of the s	215-0	in 72 ho in "natur Medicul	pleted	(Specify only highest gr	ade completed)	(0)	give kind of work done	during most of work	ing	16b. Kind of	Business/In	ndustry
The state of the s	21	ed with	Com	2nd		Ca	able Worker					ion, Inc.
Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— Maria Gloria Escobar/sister—in— in X Baria 2 clorenation as Gloria	land	lid be fill fental Hy rked oth	Be								ıme)	
Physician Medical Examiner  Process and a consideration and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Onset and Death Seventhal Between Death Seventhal Between Onset and Death Seventhal Between Death Seventhal Between Death Seventhal Between Death Seventhal Between Death Seventhal Between	Mary	nd 2 shoulth and N				in- 195 N	Jailing Address (Street 409 Lost Kn	and Number or Run life Circ 11ace Ma	le #102	r, City or Tow	n, State, Zip	Code)
Physician Medical Examiner  Process and a consideration and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Onset and Death Seventhal Between Death Seventhal Between Onset and Death Seventhal Between Death Seventhal Between Death Seventhal Between Death Seventhal Between Death Seventhal Between	ore,	ges 1 er of Hea if item or other		1 X Burial 2 ☐ Cremation 3 [		20b. Place of D cemetery,	isposition (Name of crematory or other place	ca)	Date	20c. Location	n - City or To	own, State
Physician Medical Examiner  Process and a consideration and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Between Onset and Death Seventhal Between Death Seventhal Between Onset and Death Seventhal Between Death Seventhal Between Death Seventhal Between Death Seventhal Between Death Seventhal Between	Itin	ertmer ortant Injury				ramily			.00			
Physician  Medical  Examiner  The part of the part of	B	Ded de de de de de de de de de de de de d		Manda C	Bacon	CC341						
Privisical Examiner  The color as a consequence of):  Due to (or as a cons				shock, or heart failure. List only	polications that caused to one cause on each line	he death. Do no	enter the mode of dying	ig, such as cardiac	or respiratory ari	rest,		Interval Between
Securitally list conditions, any negating to mineralize cause influence of the conditions of the condi				disease or condition	a			· injury				2 days
The standard of the standard s					Due to (or as a	consequence or)		) (				
Section   Sect		pel	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duo to (or as a	consequence of)	'n	0411	a Da	4		
FEMALE   23b. Was decedent pregnant in the past 12 months?   1   ves 2   No 3   Potably 4   Unknown   24a. Was an autopsy professor of earth?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   No 3   Probably 4   Unknown   24a. Was an autopsy prior to completion of cause of death?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   Ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2	ó	execu en and rial-tra	Exar		c Due to (or as a	consequence of)	1	tetil	[()-	2		
FEMALE   23b. Was decedent pregnant in the past 12 months?   1   ves 2   No 3   Potably 4   Unknown   24a. Was an autopsy professor of earth?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   No 3   Probably 4   Unknown   24a. Was an autopsy prior to completion of cause of death?   1   ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2   Ves 2   No 3   Probably 4   Unknown   25. Was case referred to medical examination of cause of death?   1   ves 2	876	ate be	licai		d			Moreone	PPROVED BY ME	CAL EXAMIN	ER	
The state of the s	9	certific ding p			23c. If ves. outcome o	f pregnancy		CERTIFICATION P	g 1 1 1 - 1			
The state of the s	O. Bo	ne death of the etten	ysician	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death						•
The state of the s	J.	thet the	y Ph	1	contributing to death but	not resulting in t	he underlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to I	the cause of death?
The state of the s	rds	en sign		3					1 🗆 Y	es 2X No	3 🗌 Pro	bably 4 □Unknown
The state of the s	Reco	The law re te has be age 2 sho	ompiet						autop perfor	sy m <i>e</i> d?	prior to co	ompletion of cause of
The state of the s	ital	ertifice								10		54.00
The state of the s		Physic this of al dire	2	1 Yes 2 No	Inpatien		ation 3 DOX	4   Nuising no				fy)
The state of the s	O	ding th. : After funer	tion	1 □Natural 5 □ Pending	(Month, Day	Year) Inji	iry Wor	k?				vas xilection
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  (A) Name and address of person who completed cause of death (Item 23a) (Type Print)	<u>Visi</u>	r Attar er dea rector by the	tifica	3 ☐ Suicide 6 ☐ Could not	7.2	-			28f. Location (S	treet and Nur	-	
My P/3/54 9-4-2006  30 Name and address of person who completed cause of death (Item 23a) (Type Print)	Ö	ital of urs aft rai Di			Stree			1	Howan	d Con		
My P/3/54 9-4-2006  30 Name and address of person who completed cause of death (Item 23a) (Type Print)		a Hoap 24 hou a Fund letely fi	dical	(Check only 2 Medicet Exe	minar: On the basis of e	examination and/	death occurred at the til or investigation, in my o	ne, date and place, ppinion, death occur	and due to the or red at the time, or	ause(s) and i date and place	manner as s e, and due t	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type. Print)		To th To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		-		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  EDWARD Li 22 South GREEN ST BAILL MP 1/20/  State  Registrar  SED 1 2 2006								13154		9'-9	1-200	06
State 31. Date filed (Month, Day, Year) 62. Registrar's Signature Registrar SED 1 2 2006	L	(2)			completed cause of de	ath (Item 23a) (T ろひしまり	ype, Print) GREEN ST	BA 146	mp 2	1201		
				31. Date filed (Month, Day, Year) SEP 1 2 200	2. Registrar	's Signature	arte					

	_	For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artme <i>rtifica</i>	nt of H	lealth a Death		Re	g. No.	006	
Physicia		Decedent's Name (First, Middle, La						2	2. Date of Death Month	Day	Year	3. Time of Death
/Medic	al .	Arlene	Cohen		4h Cih	. Tours o	1 continu	4 Dooth	Sept.	5,	2006 unty of Deatl	12:45 A.
Examine	er	4a. Facility Name (If not institution, giv	e street and number)			ethes	Location of	r Death		1	on tgon	
		6317 Lenox Road  5. Social Security Number 6. S	ex 7. Age (	In yrs. last birthday	If Unde	er 1 Year	ua. If Under 2	24 Hrs 8	I. Date of Birth (Month, Day,			nplace (State or Forei
uneral rector			□M 2 <b>X</b> )F	78 Yrs.	Months	Days	Hours	Min.	(Month, Day, Sept. 8,	192	7 Per	insylvania
a-f show	tor	10a. State 10b. County Maryland Montgo		Oc. City, Town or L Bethes								10d. Inside City Limi 1 X Yes 2 ☐ N
23a or 28 ast be no	ai Dire	10e. Street and Number 6317 Lenox Road			10f. Z	ip Code 20	817		10	-	of What Co	•
Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic svant, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2(  2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev. Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	er in U.S. 13.	Was Dec If Yes, sp 1 Yes		ispanic Orig in, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		Race - Ame Black, White ecify: Wh	
An "natu	pietec	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	16a. Dece (Give life.	kind of w	rork done d use retired	during most ()	of working	1		of Business/I	ndustry
트립	Con		4 Years		Hom	emake					Home	
rked oth	To Be	17. Father's Name (First, Middle, Last Walter Diehl	)						First, Middle, M Royer	aiden Sui	mame)	
27 is ma r trauma		19a. Informant's Name/Relationship ( Dr. Herbert Cohe			-				Ro <i>ute Number</i> , sda, Mar	· .		
or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		20b. Place of Disp cometery, cre Judean M				Date /6/20			on City or	
eny inju		21. Signature of Funeral Service Lice		1 2	2 Name	and Addro	of Engilib					Land 20852
sician edical miner		23a. Part1. Énter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  Metast  Due to (or as a company)	atic Canc		ode of dyin	g, such as o	cardiac or i	respiratory arre	st,		Approximate Interval Between Onset and Death 8 Months
he bu	dicai Examiner	Sequentially list conditions, if any, leading to intribuliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):								o Honens
for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin	☐Fetal death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)				23d	Date of deli	very Day Year
pe g	٥	Part II. Other significant conditions of Emphysema		not resulting in the t		cause giv	en in Part I.			accoluse		the cause of death?
has e 2	Completed								24a. Was an autopsy perform		4b. Were au prior to d death? 1  Yes	topsy findings availab ompletion of cause o 2□ No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00		Check only one			
ral dii	ဥ	1 Yes 2 No  27. Manner of Death	1 Unpatient			JOA	4 L Nur		d. Describe how			ify)
ctor: After the funer	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	e One Otene of Initial	ear) Injury	М		k? Yes 2 □ N	No				ral Route Number,
		4 Homicide determined	building, etc.	(Specify)					City or Town,	State)		
the Fun	Medical	(Check only 2 Medical Executions)	nysicien: To the best of eniner: On the basis of eniner state	xamination and/or in	vestigatio	on, in my o	pinion, deat	h occurred	at the time, da	e and pla	ce, and due	to the cause(s)
١		29b. Signature and title of certifier	Hars	M	$\left  \cdot \right ^{2}$		2599					Day, Year)
No. open and the last of the l		30. Name an address of person who Ylene Larsen,					g	020	D - +1		Marer 1.	and 20815

DHMH 17 Rev 1/2001

			For State Registrar		State of	Marylar	nd / Dep <i>Ce</i>	artment of hartificate of	lealth ar <i>Death</i>	nd Mer	ntal Hyg Be	iene g. No. 2	006	30177
	Discortation of the last of th		1. Decedent's Nam	ne (First, Middle, Las	st)					2.	Date of Deat Month	•	Year	3. Time of Death
	Physicia /Medic		Frank		S.		Carey,	Jr.		S	eptemb			11:10 a M
	Examin			If not institution, give		er)		4b. City, Town, o		Death			nty of Death	
_			5. Social Security N	ssion Val		Age (In use	last birthday	Annapo		Hrs o	Date of Birth	A:	nne Ar	rundel place (State or Foreign
	Funeral Director		214-12-	8073 1	<b>X</b> M 2□ F	83	Yrs.	Months Days		Min.	(Month, Day,	<sup>Year)</sup> 1922	Cou	ntry) 1and
	and		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or L	ocation						10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow firtual be notified at	jo	MD	Anne Ar	unde 1		nnapo]							1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Nu				apo	10f. Zip Code			10	Og. Citizen o	of What Cou	
	th with	aiD	835 Mis	sion Vall	ey Lane			2	1401			1	USA	
	ems erm	Funeral	11. Marital Status		12. Was Decede	ent Ever in U	I.S. 13.	Was Decedent of H	Hispanic Origin an, Mexican, F	n? (Specify Puerto Ric	Yes or No- an, etc.)		Race - Ameri Black, White	
5	urs afte	by Fu	1 Never Man	ried XXMarried 4 □ Divorced	Armed Force 1/2/Yes 2 If Yes, Give Year or Date	□No s: 1944		1 ☐ Yes XXNo	Specify:					hite
2-003e	72 hou nature	ted	/Sne	15. Decedent's Ec	ducation		16a. Dece	edent's Usual Occup	oation	f working		16b. Kind of	Business/Ir	ndustry
Z	nithin ne.	Completed	Elementary/Seco		College (1-4	or 5+)	1	e kind of work done DO NOT use retire	d)	ir working		Danid 4		
7	e filed within al Hygiane. other then "		12 17 Father's Name	(First, Middle, Last)			Supe	rvisor	18 Mother's	Name /F	irst, Middle, N	Print		
	ld be fental h	To Be		S. Carey,							tha De		ianio)	
ary	shou ind M ind M ind M	۲	19a. Informant's N	lame/Relationship (	Type, Print)		19b. Mail	ing Address (Street	and Number	or Rural R	oute Number,	City or Tov	vn, State, Zi	o Code)
Σ	and 2 saith a n 27 is		Ruth M	. Carey (	Wife)		835 M	ission Va	alley L	ane,	Annapo	olis,	MD 21	401
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: if Item 27 is marked other then "natural; or items 23a or 28a-f show any nury or other treumatic event, Itie Maclical Examinat must be notified at ORGS.			☐Cremation 3 ☐		ate (	cemetery, cre	osition (Name of ornatory or other pla		Date			on - City or T	
	ait. Pa artmer ortant njury			5 Other (Specify uneral Service Ligen	_	Lo		Park Cer		-7-20	06	Baltir	nore,	MD
ă	Den Imp		17	- 2. C	A			Hardesty 12 Ridge	y Funer	al Ho	ome, P.	.A. olis.	MD 21	401
			23a. Part1. Enter t shock, or hea	the disease, or comp art failure. List only	plications that cau	sed the deat	th. Do not er							Approximate Interval Between
	Physician		Immediate Cause disease or condition resulting in death)	on	a. as	me	rate	on p	neui	no	ma			Onset and Death
	/Medical Examiner		resulting in death)	(	Due to (or	as a consec	quence of):	tra						Henry
		Jer	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or	anditions, mmediate	b. Due to (or	as a conseq	quence of):							July
	executed in and ial-transit	Examiner	triat initiated event	5	c									
Ö,	ficate be executed physician and s the burial-transit	E	resulting in death)	Last	Due to (or	as a conseq	juence of):							
00/00	ficate be physicials the bur	edical			d									
X	death certii e attending id for use a	N/W	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outco	me of pregna		⊒Ectopic pregnanc				23d. l	Date of deliv	ery
ם כ		Physician/M	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknowr	□No		t at time of d		Other (specify)	у			1	Month	Day Year
ŗ	that the ed by detacl			ificant conditions o	ontributing to deat	th but not res	sulting in the I	underlying cause giv	ren in Part I.		23e. Did tob	acco use co	ontribute to t	he cause of death?
cords	law requires that the death certil as been signed by the attending 2 should be detached for use a	ed by									1 ☐ Ye	s 2 No	3 Pro	bably 4 Unknown
ည် ည	law re nas be	Completed								_	24a. Was ar autopsy	24	b. Were auto	opsy findings available impletion of cause of
ב ב	: The	S									perform 1 □ Yes 2	No No	death?	2 No
	sician certif rector	Be	25. Was case reference examiner?	_ 3	Hospital:			-t 20 004 Ott	or		heck only one	-		
5	Physic Properties	7.	1 ☐ Yes 2 2 27. Manner of Dea		1 ☐ Inp		ER/Outpatie 28b. Time of	AL BOA	4 🗀 Nursi		5 Reside			<u>(v)</u>
VISION	ath. r: Afte	ation	1 Natural 2 ☐ Accident	5 Pending investigation		Day Year)	Injury		rk? ∣Yes 2.∐No	,				
<u> </u>	To the Hospital or Attending Physicien: The law within 24 bours after death.  To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of	Injury - At h	ome, farm, st fy)	reet, factory, office		28f.	Location (Str City or Town	eet and Nu , State)	mber or Run	al Route Number,
	opital		29a. Certifier	Certifying Ph	ysician: To the be	est of my kno	wledge, dea	th occurred at the tir	me, date and p	place, and	due to the ca	use(s) and	manner as s	stated.
	the Ho iin 24 t the Fu prietely	ledicai	one)	2 Medicai Exan	niner: On the basi and manner	is of examina	ation and/or in	nvestigation, in my o	pinion, death	occurred a	at the time, da	ite and plac	e, and due t	o the cause(s)
	To To Con	Σ	29b. Signature and	I title of certifier	Total	A	z w	29c. Licens	e number	2.0	138 29	d. Date sig.	ned (Month,	Day, Year)
	51 01		39. Name and add	ress of person pro	completed cause	of death (Iter	п 23а) (Туре	Print)	r H.	11/19	Δ.	20:	ILA	6 200
	₹\ Sta	0	31. Date filed (Mor	EL J. Conth. Day. Year)	324Ren	istrar's Signa	ture	JF & EW?	E 1116.	TUH	1 / N	NH-91	4) 1/1	DUTOI
	Registr				006	Mar A	A L	e de la constante de la consta						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	tate of Maryland / Depa Ce	artment of Health and M rtificate of Death	lental Hygien	<sup>e</sup> 2006	30178				
		is.	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death				
	Physici		Lance Maurice Cour	ctnev		September	4. 2006	10:45 P <sup>M</sup>				
1	/Medic Examin	_	4a. Facility Name (If not institution, give street		4b. City, Town, or Location of Death	4	4c. County of Death					
			Prince George's Hos		Cheverly			orge's Co.				
1	/ Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 M	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Oct. 5, 1		nplace (State or Foreign untry) hington, DC				
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits				
	f eho	ō						1 ☐ Yes 2 X No				
	28a	Director	MD Calvert Cot  10e. Street and Number	inty Hunting	10f. Zip Code	10g. (	Citizen of What Co	untry?				
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "netural", or Iteme 23a or 28a-f ehow	3a or		1950 Lower Marlbon	ro Road	20639	τ	J.S.A.					
	deat	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White					
õ	or It	F	1 Never Married 2 X Married	I □ Yes 2 ሺ No If Yes, Give	1 ☐ Yes 2 X No Specify:	, , , , ,	Specify: Whi	•				
ğ	tural',	d by		Year or Dates:		1ch						
Maryland 21215-0036	in 72	olete	15. Decedent's Education (Specify only highest grade control of th	mpleted) (Give	ident's Usual Occupation a kind of work done during most of work. DO NOT use retired)	ing 180.	Kind of Business/I	ndustry				
212		Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	vice Technician	Se	curity S	vstems				
פַ	should be filed and Mental Hygin marked other matic event, II		17. Father's Name (First, Middle, Last)			(First, Middle, Maid						
<u>la</u>	ould be Mental narked c	2	Gilbert R. Courtne	<b>-</b> Δ	Elizab	eth Cookes	sey					
lan L	2 sho and lema		19a. Informant's Name/Relationship (Type,		ng Address (Street and Number or Run							
	tealth m 27		Tammy Courtney (Wit	e) 1950 20b. Place of Dispo	Lower Marlboro Ro		gtown, M Location - City or					
Baltımore,	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remo	comotoni oro	matory or other place) Sept	. 8,						
	it. Pa		4 Donation 5 Other (Specify)  21. Signature of Fund Limited	Washingto	on Nat. Cem. 2	006 LSu	itland,	Maryland				
g	permit. Pages 1 and 2 should b Depertment of Health and Ments Importent: If Item 27 Ie marked eny injury or other traumatic e ong.		Mi object W Tog	0-	2. Name and Address of Facility Le 125 Southern Maryl	e Funeral	Home Car	vert, P.A.				
pril)	* *		23a. Part1. Enter the disease, or complicati	ons that caused the death. Do not en			OWILIGS	Approximate Interval Between				
	Physician		shock, or heart failure. List only one c immediate Cause (Final		A. A. 1			Onset and Death				
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	organ failure			1 day				
	Examiner		Samontially list conditions	Sepsis								
P.	p #	ner	S quentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a consequence of):								
	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Du to (or as a consequence of):								
8760,	ate be executed hysicien and the burial-transit			Dur to (or as a consequence or).								
687		dical	d. =									
ROX	death certific e ettending pl ed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy	-		23d. Date of deli	very				
ň	death e ette d for	cia	in the past 12 months?	4☐ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year				
J.	by the	hys	9 🗆 Unknown	9 Unknown								
VITAL RECORDS, F sicien: The law requires tha	taw requires that the de as been signed by the e 2 should be detached f	þ	Part II. Dther significant conditions contrib  Acute rend .	uting to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobaco		the cause of death?  obably 4 Wonknown				
ပ္သ	aw requir s been si 2 should	Completed	s troke			24a. Was an	24b. Were au	topsy findings available				
ř	The tate happened	E O	Congestive hi	eart failure		autopsy performed 1 Yes 2	death?	completion of cause of				
<u>E</u>	sartifica ctor,	Bec	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)						
	Physicien: The lav this certificate has al director, page 2	은	1 Yes 2 No	1 Inpatient 2 EN/Outpatie		me 5 🗆 Residence		cify)				
Division of	Viter Aner	Certification:	1 ☑Natural 5 ☐ Pending	(Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred					
<u>s</u>	or Attend after death Director:	cat	2 Accident investigation 3 Suicide 6 Could not be	Se Place of Injury - At home farm st	M 1 Yes 2 No	28f. Location (Street	and Number or Bu	ral Boute Number				
<u>≥</u>		ertil	3 Suicide 4 Could not be determined 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	To the Hospital of within 24 hours affice To the Funerel Discompletely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	he Ho in 24 i he Fu pletely	edical	(Check only 2 Medical Examiner:	On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date a	and place, and due	to the cause(s)				
	To t COM	Σ	29b. Signature and title of certifier	٨	29c. License number	29d. I	Date signed (Month	n, Day, Year)				
			Donal a	lexander MD	D25812	7,	14/06					
	10		30. Name and address of person who comp	eted cause of death (Item 23a) (Type	Print)	celli m	21128	5				
	Sta	ato.	DANIEL HIEKAI  31. Date filed (Month, Day, Year)	32. Register's Signature	TIME DE CHEVE	ry III	2070					
	Registi		SEP 7	2006 > Elean H.	DSZBIS  PITAL DR CHEVE							

State of Maryland / Department of Health and Mental Hygien 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year August 29, 2006 James William Carr 1:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown 8. Date of Birth (Month, Day, Year) Aug. 9, 1926 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 ★ M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 80 Yrs Washington, DC 228-26-8702 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show the Medical Exeminer must be nutified at 1 ☐ Yes 2X No Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21895 Pegg Road, Apt. #237 20653 United States death or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No þ Specify Specify. 3 ☐ Widowed 4 ☐ Divorced WW II White "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Residential other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental H tent: If Item 27 is marked off Be James E. Carr Olive I. Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21895 Pegg Road, Apt. #237, Lexington Park, MD20653 Janice Earline Carr (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 9/6/2006 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dementia /Medical Due to (or as a consequence of) Examiner olitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Dehydration intake or Attending Physicien: The law requires that the death certificate be executed 0000 Due to (or as a consequence of): Box 68760, physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ gastus intestinal HUSTOM 4 🗹 Unknown 3 Probably 1 ☐ Yes 2 ☐ No. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manney of Death 28b. Time of 28d. Describe how injury occurred s after dea... rel Director: Aft 1 Natural 5 🗌 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 \ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my includedge idealn occurred at the time, data and place, and due to the daugs(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 060888 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan, M.D. 26840 Point Lookout Road #101, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 2006 Registrar

		Registrar	of Maryland / I	Departme Certifica	ent of Healt ate of Dea	h and M th		Rag. No	2006	
Physicia /Medica	_	Decedent's Name (First, Middle, Last)     Katherine Davenpor					2. Date of Do Month Septem	ber Day	7 2006	3. Time of Death 2:00 A M
Examine Funeral		4a. Facility Name (If not institution, give street and not have the Holy Cross Hospital  5. Social Security Number 6. Sex		rthday) If Und	der 1 Year If Un	er Spri	ng  8. Date of Bi			gomery  blace (State or Foreign
Director		237-62-6831 1□M 2K F Usual Residence of Decedent	66	Yrs. Month	S Days Hou		Oct. 1	7, Year)	939 Nort	h Carolina
Mary jarin 2.12.13-0030 nd 2 should be filed within 72 hours after death v th and Mental Hygiene. 27 is marked other than "natural", or items 236 r traumatic event, tra Medical Examinar must	To Be Completed by Funeral Director	Amed 1    Never Married 2   Married 3   Widowed 4   Divorced	rive cedent Ever in U.S. Forces? 2 2 No Sive Dates:  16a  19t 20b. Place cereative	13. Was Deit Yes, s 1 Yes  Decedent's U (Give kind of life. DO NOT)  Admini	cedent of Hispanic pecify Cuban, Mexico Specify Cuban, Mexico Specify Coupation work done during Tuse retired)  Strative  18. M  18. M  TATIVE	O747 C Origin? (Special, Puerto city:  most of works: Assis lother's Name	ecity Yes or N. Rican, etc.)  ing  stant b (First, Middle Bern al Route Number 2077)	16b. K  , Maiden  ice  ice  icity 4  2  20c. Lo	izen of What Cou United S 14. Race - Ameni Black, White, Specify: ind of Business/In	tates can Indian, etc. Black idustry rnment
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cancer of Right Breast  Due to (or as a consequence of):									
at the death certificate be death certificate be death certificate be do by the attending physicileteched for use as the bu	by Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   ZNo 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 5   Other (specify)   Month Day  4   Pregnant at time of death 9   Unknown  Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23d. Date of delivery Month Day  4   Pregnant at time of death 9   Unknown   Solution   Day   Day of Solution   Day								Day Year he cause of death?
nysician: The law renticate has bee	Completed	Hypoxia Hypertension		····					prior to co death?	opsy findings available impletion of cause of
ing Pl	atlon; To Be		All Spital:  1 St Inpatient 2 ER/Outpatient 3 Spital:  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M			Nursing Ho		y one) sidence 6 □Other (Specify) e how injury occurred		
_ 5 5 <u>e</u> 9	Certification;	3 Suicide 6 Could not be determined but	arm, street, fact							
To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Check crity one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check crity one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		Robert H Lua  30. Name and address of person who completed	wl MO		D005				eptember	
Stat Registra		Robert H. Ger		1500 F	orest G1	en Rd.	, Silv	er Sj	pring, M	D 20910

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/200

Registrar

SEP 1 1 2006

	1 - St	er ete egistrar	State o	f Marylan		artment e rtificate				giene∠ ( Reg. No.	100	30182
Physicia	n	edent's Name (First, Middle		E.	NO	RSE	<b>Y</b>		2. Date of De Month	Day	Year 2006	3. Time of Death
/Medica Examine Funeral	4a. Fed HOW 5. Socia	illity Name (If not institution  AND CONTY  al Security Number	, give street and nur	HOSP 7. Age (In yrs.	PITAL	4b. City, To	wn, or Locat	BIA-	8. Date of Bir (Month, Da NOV 12	4c. Count	y of Death  WAS	
Director	Usual F	1-86-0096 Residence of Decedent ate 10b. County		10c. Cit	ty, Town or Lo				NOV 15	1 1 1 0 0 0		10d. Inside City Limits 1 ☐ Yes ※ No
death with the Maryland me 23a or 28a-f ehow Livest by rectified at	10e. St	reet and Number	Aldiaci			10f. Zip C				10g. Citizen of	What Cou	
after death v	11. Ma	yland Anne reet and Number 0 Dopeco ( rital Status  Never Married XXMarr	12. Was Dece Armed Fo 1 Yes If Yes, Giv	edent Ever in U rces? 2)() No					ecify Yes or No Rican, etc.)	USA 14. Ra Bla	ce - Ameri ick, White, fv: B	
S - 3	3 - 3 -	Widowed 4 □ Divorced	Year or D Year or D Year or D Year or D College (1	ates:	16a. Dece	dent's Usual ( kind of work DO NOT use	Occupation		ing	16b. Kind of E	Business/In	
al Hyg	17. Fat	12th her's Name (First, Middle, eodore Pat:			Acc	ounta	18. M		First, Middle Pugh	Servio , Maiden Suma		
tand 2 shows the stand 2 shows the stand 2 shows the stand the stand the standard t	19a. Ir Ma 1 20a. M	nformant's Name/Relations  10n Dorse ethod of Disposition	(Husban	20b. F		Dope	co Ct	. Ode		er, City or Town  Md . 2  20c. Location	1113	
Dalitimore, permit. Pages 1 a Department of Hee importent: if Item any injury or othe once.	4 [	∑ Burial 2 ☐ Cremation ☐ Donation 5 ☐ Other (Signature of Funeral Service	pecify) Licensee	Ch	urch	Cemet	ery	9-7-		Columl		Md.
Physician /Medical	Immed diseas	Part1. Enter the disease, or shock, or heart failure. List diate Cause (Final se or condition ing in death)	complications that conly one cause on e	PTIC	th. Do not ent	er the mode	of dying, sucl			S, Md. rrest,	2140	Approximate Interval Between Onset and Death
examiner executed and ial-transit	cause Cause that in	entially list conditions, leading to immediate Enter Underlying (Disease or injury strated events ng in death) Last	b. CO	(or as a consection as a conse	JOPF Judnice vil).		ensī.	CA	NCCE	2		
death certifi	IF FEM 23b. V	MALE: Vas decedent pregnant In the past 12 months?  Yes 2 □ No	1 ☐ Live t	come of pregnation 2 Teta pant at time of course	aldeath 3	⊒Ectopic prec ∃Other (spec					ate of deliv onth	ery Day Year
ta en en en en en en en en en en en en en		Other significant conditi	ons contributing to d	eath but not res	sulting in the u	nderlying cau	se given in P	Part I.		tobacco use cor Yes 2 No		he cause of death? pably 4 Unknown
The The page	Completed					1:			1 Yes	psy ormed? 2 No		opsy findings available impletion of cause of
h his	ex.	as case referred to medical aminer?  Yes 2 No common 1 Death  Natural 5 Pendical Properties invest	Hospital: 1 28a. Date (Mon		ER/Outpatier 28b. Time o Injury		Other	Nursing Ho		one) idence 6 ⊡Ot how injury occu		(y)
ital or Attend urs after death rel Director:	3 [ 4 [ 4 [	Suicide 6	hined 200. Flace build	of Injury - At h ing, etc. <i>(Speci</i>	<i>fy</i> )				City or To	wn, State)		al Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled		Certifier Certifyi (Check only one)  Signature and title of certifie		a best of my kno asis of examina ner stated.	owledge, deat ation and/or in	vestigation, in	the time, dat n my opinion, License num	death occur	and due to the red at the time,	cause(s) and m date and place 29d. Date sign	, and due t	o the cause(s)
T Will		In o	2 ()e	z n	~ and an an an an an an an an an an an an an		541	24	8	9/	121	106
15	01.0	and address of person  GORG  ate filed (Month, Day, Year	$\epsilon$ $T$ .	se of death (Iter	AN	9						
Stat Registra	e	and the same of th	A 6000C	1	A.	Buch	) * 1					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2005 30183 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Terri Loucil Elbert 10:00 AM September 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3404 Dodge Park Rd., #201 Landover
If Under 24 Hrs. Prince George's 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF Hours Min Director 577-88-4127 July 30, 1959 Florida Usuel Residence of Decedent filed within 72 hours after death with the Maryland Show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral, or itema 23a or 28a-f shov Examiner rount be nutified at Director 1X Yes 2 □ No Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Dodge Park Rd., #201 20785 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. I ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Completed by Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced in Medical Ex-Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Charles W. Elbert Geraldine Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chauntel Elbert/Daughter 3404 Dodge Park Rd., #201 Landover, MD 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 9/9/2006 Landover, MD 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician <u>Glioblastoma</u> /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 ☐ Yes 2 🖁 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2X No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D19431 September 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank M. Ryan, M.D. 11701 Livingston Rd., #203 Ft. Wash., MD 20744 B2. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 30 | 84

		•	1 - For State Registrar	State of Mary	(	Certifica	te of L	Death		Reg. No.	200	0	00	104
d Se	4 France		Decedent's Name (First, Middle, Las	t)					2. Date of De Month	ath Day	Y	ear	3. Time of (	Death
	Physicia /Medic		JOSEPH E	LVIS					Sept.		006	C	0619	М
	Examin	100	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of Death		4c.	County of	Death		
			Arundel Medical C	enter		Anna	poli:	S			ne Ai			
107	Funeral		Social Security Number     6. Security Number	EM 2DE	yrs. last birth	Months		If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)			ce (State or	· Foreign
1	Director	-	UNKNOWN	88	Yr	S.			April	11,1	918 (	Guyar	ıa	
	pue ≱_		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town o	or Location						10d	I. Inside City	y Limits
	Aaryii F sho	ъ			)() D								† <b>⊘</b> Yes	2 🗌 No
	28a-	ect	Md. Prince G	eorges	Mt. Ra		p Code			10a. Citi	zen of Wha	at Country	v?	
	with a or	<u>=</u>	3230 Chillum Road				712			-	S.A.	ĺ		
	leath	Funeral Director	11. Marital Status	12. Was Decedent Eve	r in U.S.			spanic Origin? (S n, Mexican, Puert	pecify Yes or No		14. Race -			
	r Iten	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2∑ No					o Rican, etc.)			White, etc		
ğ	urs a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	-	1 🗌 Yes	200 No	Specify:			Specify:	Втас	k.	
P	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23a or 28a-f show atto event, the Mexical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. D	ecedent's Usi	ual Occupa	ation during most of wor	deina	16b. Kii	nd of Busin	ness/Indu	stry	
Z	thin 7	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	—— i	ite. DO NOT	ise retired,	)	nary					
21215-0036	er th	PO I		4yrs	Mes	ssenger					ernme	nt		
Maryland	al Hy al Hy d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden	Sumame)			
<u>X</u>	Ment Ment arke	2	Unknown					unknov						
a	2 she and Is m	1	19a. Informant's Name/Relationship (7	ype, Print)	19b. A	Mailing Addres	s (Street a	and Number or Ru	iral Route Numb	er, City o	Town, Sta	ate, Zip C	ode)	
	and ealth m 27 ner tr		Clairmont Elvis/					Road, Mt	. Ranier				- 0	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, the Marical Examiner must be notified at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of D cemetery,	crematory or	other place	e)	Date	20c. Lo	cation - Cit	y or rown	n, State	
Ξ	Pag ment ant: lury		* 4 ☐ Donation 5 ☐ Other (Specify		Mt. 01i			ry 9/9/	06	Wash	ingto	n, D	.C.	
Za Za	epart poart ny in		21. Signature of Funeral Service Licen	500				s of Facility					lc. 20	
_	70 E 9 9		Jusin 1	2 Jane	-			Jenkins			enned			
0			23a. Part . Enter the disease, or comp shock, or heart failure. List only	olications that caused the one cause on each line.	e death. Do no	t enter the mo	de of dyln	g, such as cardia	c or respiratory a	rrest,		lr.	Approximate Interval Betwonset and D	veen
1	Physician		Immediate Cause (Final disease or condition	a Utose	PSis									
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of	):								
	LAUMMEN		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co										
	ed sit	Examiner	rt any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a co	onsequence or	,.								
	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of	):								
9	rificate be executed ng physicien and as the burial-transit	ajE		,										
68760,	icate phys s the	Aedicai		. d										
		/Me	IF FEMALE:	23c. If yes, outcome of p	oregnancy					2	3d. Date o	of delivery	,	
Box	that the death ce ed by the attendir detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		3 ☐ Ectopic p 5 ☐ Other (s					Month			'ear
P.O.	the d y the iched	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
٣	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significent conditions of	ontributing to death but n	ot resulting in t	he underlying	cause give	en in Part I.	23e. Did t	obacco u	se contribu	ute to the	cause of de	eath?
rds,	puires n sign ald be								1 🗆 1	Yes 2	⊒K6 3[	☐ Probab	oly 4 □U	nknown
Record	w require s been sis	Completed							24a. Was				y findings a	
æ	<u>ө</u> - <u>ө</u>	mc								rmed?	dea	ith?	oletion of ca ☐ No	use of
Vital	ician: Th certificate rector, pag		25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only o	2 No	1	Yes 2	L No	
	Physician: r this certificatal director,	To Be	examiner?	Hospital:	2 □ ER/Outo	atient 3 C	OA Othe	00	dome 5 ☐ Resi		Other	(Specify)		
ō	a Physeratic		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Tir		28c. Injury Work		28d. Describe			77		
Division	Attending r death. sctor: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		ear) in	ury M		Yes 2 □No						
VIS.	Atte	ifici	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injury	- At home, farn	n, street, facto	ry, office		28f. Location ( City or To			or Rural F	Route Numb	ber,
á	al or s afte il Dir	Certification:	4   Homeda	building, etc. (	эр <del>ө</del> спу)				City or 70	wii, Otalo,				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledge,	death occurre	d at the tim	ne, date and place	and due to the	cause(s)	and mann	er as stat	ed.	
	he Hos n 24 h he Fur pletely	edicai	one)	niner: On the basis of ex		or investigatio	n, in my of	pinion, death occi	uried at the time,	date and	place, and		ne cause(s)	
	To the Hospital within 24 hours a To the Funeral Completely filled	Σ	29b. Signature and title of certifier	4		2	c. License	_			e signed (/			
,			Sleph (		10			58510		0	9/0	1/00	6.	
R	- (1)		30. Name and address of person who	completed cause of deat	h (Item 23a) (T	ype, Print)	200	1 Medica	1 Dler ***	A nn	no14	LW D	017.4	0.1
1			Stephen	Olere	A	+wice	. 200	T FIEUTCS	IT I'KWY,	AIIII	*horr	s Ma	. 414(	ΩŢ
	Sta		31. Date filed (Month, Day, Year)											

State of Maryland / Department of Health and Mental Hygien 2005 30185 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret  $\mathbf{F}_{\bullet}$ Edwards September 4, 2006 1918 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ☐ M 2 🔼 F Months Days Hours 87 023-03-6251 Director Sept 29, 1918 Mass. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "netural", or items 23e or 28e-f show traumetic avant, the Medical Examiner must be notified at MD 1 Yes 2X No Calvert Prince Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7050 Homeland Court 20678 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. '7 is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Bus Aid Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Filippo Floromo Rosie Montone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If itam 27 is a 7050 Homeland Court Prince Frederick, MD William E. Edwards (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept 14. 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State Department of Important: If any injury or once. Arlington Nat. Cem. 2006 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Ft. Myer Virginia 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signatur of Ineral Service Licensee J. GOZÍ 8125 Southern Maryland Blvd. Owings, MD 20736 eary 23a. Agrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause pusease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Respiratory 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Renal 24a. Was an autopsy performed2 Airway Obstructive direase Chronic 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 tha Hospital or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funaral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To tha 29c. License number 29d. Date signed (Month, Day, Year) 9-5-2006 D 50653 GYAN. C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851-Church ton Deale 31. Date filed (Month, Day, Year) 32. Registra Signature State SEP 2006▶ Registrar

		For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Maryland	•	artment of tificate of		2. Date of Dea	Reg. No. 200	3. Time of Death
Physicia /Medica Examine	al -	Rodney William For 4a. Fecility Name (If not institution, give st 347 N. Cannon Aver	reet and number)		Hagers		Sept.	8 200 4c. County of D Washir	ngton
Funeral Director		5. Sociat Security Number 218-88-6590 6. Sex 130 Usuel Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	tf Under 1 Yea Months Day		Hrs. 8. Date of Birt (Month, Da 06/22/	y, Year) 1961	Birthplace (State or Foreig Country) MD
e Maryland Ba-f ehow	ctor	10a. State 10b. County MD Washingtor		, Town or Lo agerst	own			40. 00	10d. Inside City Limits  10d. Yes 2 □ No
3a or 2	i Dire	347 N. Cannon Aver	nue		10f. Zip Code 21740			10g. Citizen of Wha	t Country !
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural" or Iteme 23a or 28a-f show ery injury or other traumatic event, the Medical Examinar mant be notified at once.	by Funeral Director	11. Maritat Status  1 1 Naver Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of if Yes, specify Cu 1 ☐ Yes 2 🕱 N		? (Specify Yes or No uerto Rican, etc.)	Btack, V	American Indian, White, etc. White
within 72 hou ane. then "neture the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usuat Occ kind of work don DO NOT use retii	upation e during most of red)	working	16b. Kind of Busin	ess/Industry
uid be filed v Aental Hygie rked other i tic event, II	To Be Co	17. Father's Name (First, Middle, Last)  Roger William Ford	cino		21011	18. Mother's	<sub>Nam<i>e (First, Middl</i>e, da Fay Lev</sub>	Maiden Surname)	
d 2 sho		19a. Informant's Name/Relationship (Type Roger W. Forcino /		19b. Maitir 347	ng Address (Stre N. Cani	et and Number o non Aven	r Rural Route Number ue, Hager	er. City or Town. Sta stown, MD	te, <i>Zip Code)</i> 21740
of Heal of Heal or other		20a. Method of Disposition 1	20b. P	lace of Dispo emetery, crei	sition (Name of matory or other p	lace)	Date /10.006	20c. Location - Cit	
permit. Pag Department Important: eny injury o		* 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License	ке	) 22	2. Name and Add	Iress of Facility		Minnich :	WII, MD Funeral Home , MD 21740
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one timmediate Cause (Final disease or condition resulting in death)	cations that coused the deatle cause on each line.  Cevcbvab  Due to (or as a conseq	Palsy	er the mode of d	ying, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death YEARS
certificate be executed was ding physician and see as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
death e atter	Physician/Medio	IE EEMALE.	3c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d	death 3	□Ectopic pregnar □ Other (specify)			23d. Date o Month	f detiv <i>e</i> ry Day Year
uires that t signed by Id be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	inderlying cause	given in Part I.	23e. Did t		ite to the cause of death?  Probably 4 □Unknow
The law requires that the sate has been signed by the page 2 should be detached.	Completed						24a. Was auto perfo	psy prio ormed? dea	re autopsy findings availab r to completion of cause of th? Yes 2 \( \text{No} \)
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	ER/Outpatie	nt 3 DOA	Oth ac	Death (Check only on Home 5 Resi		(Specify)
or Attending Physician: ifter death. Diractor: After this certific in by the funeral director.	ation: To	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	of 28c. In		28d. Describe	how injury occurred	Эрөспу
tal or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of tnjury - At h building, etc. (Specif	om <i>e</i> , farm, st	reet, factory, offic	ce ce		Street and Number ( wn, State)	or Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deal ition and/or in	th occurred at the evestigation, in m	time, date and p y opinion, death	place, and due to the occurred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of addier	8/02			onse number	3	29d. Date signed (#	Month, Day, Year)
H-T		30. Name and address of pers in who co		n 23a) (Type	Print)	Denne	3 .p Bol	A 12 12 12 12 12 12 12 12 12 12 12 12 12	
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	Indick!	RAVEE	7.000	RICOWI	

06-06499

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death Edward Hartley Farrell 2006 30187 1- For State

			Registrar		Certificate C	Deaui				Reg. No.	200	
	Physicia al Exami	ner	Decedent's Name (First, Middle, Li     Edward	Hartley	Farrel				2. Date of De Month August 3	0, 2006	Year	3. Time of Death 0909 hrs
			4a. Facility Name (if not institution, g 615 Clay Hammond Roa			4b. City, Town Prince Fi		on of Death		Calve	inty of Dea e <b>rt</b>	ith
	Funeral	-			yrs. last birthday)	If Under 1	Year If U	nder 24Hrs.	8. Date of B	lirth(MM/DD/Y		irthplace (State or
	Director		213–50–0331	13m 2 F 58	Υ	Months I	Days Ho	urs Min.	Jan 1	4 1948	Fore	eign Country <b>Washingto</b>
		ŀ	Usual Residence of Decedent						1			
	w any		10a. State 10b. County		. City, Town or Loca							10d. Inside City Limits
l l	Aaryland 28a-f show 1 at once.	ē	Maryland Calvert	t	Prince F					100		1 Yes 2 X No
	e Mary or 28a fied at	Director	10e. Street and Number 615 Clay Hammon	nd Road		10f. Zip Cod 2067				10g. Citizen o United		
	hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	를	11. Marital Status	12. Was Decedent Eve	r in U.S. 13. W	Vas Decedent of		Origin? ( Spe				erican Indian, Black,
	eath v	Funeral	1 Never Married 2 Marrie	A amount F = 40000?	If	Yes, specify Cu					White, etc.	white
	after d	by Fi	3 Widowed 4 X Divorce	ed If Yes, Give Year or Dates:	1	Yes 2 X	No spec	afy:		Spec		wiiice
	2 hours afte "natural",  Examiner		15. Decedent's Education (Specify			ent's Usual Occi most of working				16b. Kind o	of Business	s/Industry
	22 = =	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	land	survey	or			surve	evor	
Ö	filed within 72 I Hygiene ed other than " t, the Medical I	影	17. Father's Name (First, Middle, La	st)				her's Name	(First, Middle	, Maiden Surn	-	
21215-0036	buld be file Mental H marked o	Be (	Justin Edward Fa	arrell						artley		
	should and Me 7 is man		19a. Informant's Name/Relationship			ng Address (S						
Σ	l and 2 s Health ar item 27 r traums		Stephen J. Farre  20a. Method of Disposition	11- brother	20b. Place of Dispo				Prince Date			MD 20678 or Town, State
_			1 Burial 2 X Cremation	3 Removal from State	crematory or o	اعممانهم سانمه	-	l l			•	Virginia
<u>ti</u>		-	4 Donation 5 Other Speci 21. Signature of Funeral Service Lic			Name and Add			ıce	hickar		VIIginia
Ba	permit Depart Impor injury	ļ	(A(~)	200				Rai		uneral		
Ph	ysician	$\dashv$	23a. Part I. Enter the disease, or confailure. List only one cause on	mplications that caused the	death. Do not enter	05 Broom	ing, such a	S RO	respiratory a	rrest, shock, o	r heart	D 20676 pproximate Interval Between Onset and
	Medical kaminer		Immediate Cause (Final disease	a Intraoral Gunshot \	Vound							Death
Ī			or condition resulting in death)	Due to (or as a conseque	ence of):							
		اةِ	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):							1
	_	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):							
	xecuted n and - transit		events resulting in death) Last	d	, 							
	e be exec ysician a burial - 1	an/Medical	UNPENDED	AMENDED								
68760,	ficate I g phys the bu	ş	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome o		etal death	3 Ect	opic pregnar	201	23d Da	te of delive	Day Year
89	n certii ending use as	cial	past 12 months?	4 Pregnant at time	of death	Other (Specify)	3 <u></u>	opic pregnar	icy	Wildin	uı	Day Teal
Box	e deatl the att ed for	Physici	1 Yes 2 No 9 Unkno	9 OHKIOWII								
P.O.	ires that the death certiff signed by the attending I be detached for use as i		Part II. Other significant condition	ns contributing to death bu	t not resulting in the	e underlying cau	ise given ir	n Part I.				to the cause of death?
J,	requires been sign hould be	Completed by	<u></u>		<u> </u>				24a. Wa			autopsy findings available
Sor	law requir has been s 2 should	힅								opsy formed?	prior to death?	completion of cause of
Rec	ician: The certificate rector, page		OF Management and the medical	<del></del>		26.5	loop of Da	ath (Check o	1 Yes	2 No	1 🗸 `	Yes 2 No
<u>it</u> al	sician is cert irecto	a	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Outpatie		Other:		Home 5	Residence	6 🗸 Oth	er: Scene
Division of Vital Records,	ding Phys 1. After this funeral di	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o		Injury at W	/ork?	28d. Describe	e how injury or		
on	tendin eath. or: A the fu	흲	1 Natural 5 Pending 2 Accident Investig		FOUND: 0900 hrs	1[	Yes 2	<b>✓</b> No	Subject sh	ot seif		
<u> </u>	l or Attend after death. Director: d in by the f	Certification:	3 Suicide 6 Could n	28e. Place of Injury	- At home, farm, str	reet, factory, off	ce building	g, etc.	28f. Location or Town,		umber or F	Rural Route Number, City
	spital or nours after neral Dir filled in	Cert	4 Homicide determi	ined (Specify) Single	Family			ļe			Road, P	rince Frederick, MD
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	g	(Check only   Certifying Phys	sician: To the best of my kn ner:On the basis of examina								
	To t with To t	Medical	29b Signature and title of certifier	and manner stated			ense num					fonth, Day, Year)
			Man Shan	ull MD	~	0	.C.M.E.			August	31, 200	6
			30. Name and address of person when	no completed cause of death	ı (Item 23a)			-				
	-		Melissa Brassell, MD	Assistant Medical Ex	caminer 111	Penn Stree	t. Baltim	ore. MD	21201			
	U		31. Date filed (Month, Day, Year)			perte						

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** James Oliver Foote, Sr. 1010 M Aug 27, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral Date of Birth (Month, Day, Year) Days Min Months Hours 1**X**) M 2□ F 216-12-4973 Director 88 Maryland Jun 6, 1918 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show of Health and Mental Hygiene. I item 27 ie markad other than "neturel", or items 23a or 28a-f shov r othar treumatic event, the Medical Exami art must be multified at Be Completed by Funeral Director 1 Yes 2 No Calvert MD Lushy 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 391 Sollers Wharf Road 20657 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Yes 2 □ No If Yes, Give 1944 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Black 3X Widowed 4 □ Divorced 1946 Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Dry Wall Finisher Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental I out: If item 27 le markad of Charlotte Ann Bishop William Alexander Foote 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1475 Solomons Island Road Huntingtown, MD 20639 Martha Mackall/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or = 5 09/02/06 St. John UMC Cemetery Lusby, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No l Director: A d in by the fu 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) dete ined 4 Homicide Vithin 24 hours are
To the Funerel Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 may le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kioumarce Yazdani, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 2006 Registrar

		1	1- State of Maryland / Department Certificate	of Health and Me of Death	ntal Hygien	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) THOMAS LEE FAIR	1	Date of Death Month Deptember	3. Time of Death 17 2006 8:50 P M
)	Examin	er		wn, or Location of Death Linster Year   If Under 24 Hrs.   8	. Date of Birth	c. County of Death  Carroll County  9. Birthplace (State or Foreign
	Funeral Director			Days Hours Min.	(Month, Day, Yea,	1933 Maryland
•	e Maryland Sa-f ehow	ctor	Maryland Carroll County 10c. City, Town or Location Taneytown			10d. tnside City Limits 1 ☐ Yes 2 💆 No
	ath with th	Funeral Director	10e. Street and Number 10f. Zip C 217	787	Uni	Citizen of What Country? ted States
980	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Modical Expirities must be notified at once.	Ď	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes, Sive Year or Dates:  13. Was Decedent Ever in U.S. Armed Forces? 14 Yes, Give Year or Dates: 15. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Forces? 19. Was De	nt of Hispanic Origin? (Specif Cuban, Mexican, Puerto Rid No <i>Specify</i> :	y Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	d within 72 h giene. or then "natu ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  15. Decedent's Education (Give kind of work life. DO NOT use Sign Work)	done during most of working retired)		Kind of Business/Industry tside advertising
land	should be file ind Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) George Marlin Fair	18. Mother's Name (F Dorothy 1		en Sumame) Overholtzer
	is 1 and 2 she of Health and item 27 is ma other traums		Maxine P. Kennedy / sister 429 Quaker		Jnion Bri	dge, Maryland 21791
Baltimore,	permit. Peges 1 Department of H Important: If ite eny injury or ott once.		20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State  4 Donation 5 Other (Specify)	natorium Sep	. 19 2006 Smi	Location - City or Town, State thsburg, Maryland
Ba	Depari Depari Impor		Man C. Lurin 136 East	Baltimore St		neytown, Md. 21787
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	WITH E	X TEN 21	Approximate Interval Between Onset and Death
		niner	Sequentially list conditions, f any, teading to immediate cause. Enter Underlying Cause (Disease or injury	. H_D		
8760,	sate be executed hysicien and the burial-transit	lical Examiner	that initiated events c.  Due to (or as a consequence of):  d			
P.O. Box 6	Attending Physicien: The law requires that the death certificate be executed to death. The death of death are death.  actor: After this certificate has been signed by the eitending physicien and by the funeral director, pege 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (spec			23d. Date of delivery Month Day Year
rds, P.	w requires that is been signed by should be deta	þ	Part II. Other significent conditions contributing to death but not resulting in the underlying cau	se given in Part t.	23e. Did tobacco	use contribute to the cause of death?
Division of Vital Records,	: The law re cate has be , pege 2 sh	Completed	AAA ARRYTHMIA		24a. Was an autopsy performed?	
f Vits	Physician: The I this certificate ha al director, pege	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospitat: 1 Impatient 2 ER/Outpatient 3 DOA	26. Place of Death (Cother: 4 Nursing Home		6 ☐Other (Specify)
sion o	ending Ph sath. or: After th he funeral	Certification:	2 Accident investigation M	. Injury at 286 Work? 1 ☐ Yes 2 ☐ No	d. Describe how inj	jury occurred
<u> </u>	i i i i i i		3 Suicide 6 Could not be determined 28e. Ptace of tnjury - At home, farm, street, factory, of building, etc. (Specify)		City or Town, Sta	
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at a control on the basis of examination and/or investigation, in and manner stated.	the time, date and place, and my opinion, death occurred	d due to the cause( at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)
	withi To 1	Σ	2	icense number 005 4 5 80	0	Oate signed (Month, Day, Year) 9/18/2006
1	14		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAS/M FAKHAR, M.D., 417 E LALT ST	# D, TA	NEYTOW	N MD 21787
	Sta Registr		31. Date filed (Month, Day, Year) - 32. Registrar's Signature			

			1 - For S Registrar	tate of Maryland		rtment of He tificate of D		Mental Hy	gien Reg. N	- 2 N N	5 30	190
3	Physicia	an	Decedent's Name (First, Middle, Last)				-	2. Date of De Month Sept. 9	D:	ay Year	3. Time of t	Death OP M
	/Medic		Jacquelyn Gannett  4a. Facility Name (If not institution, give stree	et and number)	1	4b. City, Town, or	Location of Dea			c. County of De		UP ···
	LAdillill	61	Genesis Eldercare			Sever	na Park		A	nne Aru	ndel	
	Funeral Director		5. Social Security Number 6. Sex 110-20-3004	7. Age (In yrs. las 79	t birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min		rth a <i>y, Year</i> 1 <b>,</b> 1	9. B 927 Ne	rthplace (State or Country) W York	Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Loc	cation					10d. Inside City	y Limits
	a-fah	ctor	Maryland Anne Arun	del	Ar	mold					1 🗆 Yes	3√□No
	th with the 23a or 28 ast be no	ai Director	10e. Street and Number 457 Mason Lane			10f. Zip Code	1012		•	itizen of What C ISA	country?	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any figury or other traumatic event, the Madical Examinar mout be notified a once.	by Funerai	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? I ∐Yes 2 MNo If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar ☐ Yes 2 XNo	spanic Origin? (S n, Mexican, Puel Specify:	Specify Yes or No rto Rican, etc.)	0-	14. Race - Am Black, Wh Specify:		
ה ה	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade co.	on mpleted)	(Give I	ent's Usual Occupa kind of work done di	uring most of wo	orking	16b. l	Kind of Busines	s/industry	
7	within ene. than "	Completed		College (1-4or 5+)	life. D	00 NOT use retired) Iomemaker			0	wn Home	:	
and 2	e filed Il Hygi other	0	17. Father's Name (First, Middle, Last)	3				me (First, Middle	, Maide			
<u>Yal</u>	Menta Menta arked	To B	Ignasius Fessler	····				el Francl				
Mar	d 2 shouth and 7 is m		19a. Informant's Name/Relationship (Type, M. Clifford Gannet			g Address <i>(Street</i> a. Stockton						851
nore,	Pages 1 an ent of Heal nt: If Itam 2 ry or other		20a. Method of Disposition  1 XBurial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	20b. Plac	e of Dispos	ation (Name of atory or other place ans cemete		Date 13/06	20c. L	ocation - City o	r Town, State	
Dalling	permit. I Departm Importa any Injur		21. Signature of Funeral Service Licensee	Pridger	22. 65	Name and Address	s of Facility BI	EALL Funda., Bowie	eral , MD	Home 20715		
	Physician	8	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	ons that caused the death. ause on each line.	Do not ente	or the mode of dying	, such as cardia	ac or respiratory a	rrest,		Approximate Interval Betwonset and D	reen
*	/Medical Examiner	er	resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer  Due to (or as a consequer	nei	5 0	dame	ntia			year	2
,00,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):							-
0	ng phy as the	Medic	IF FEMALE.									
O. DOX	he death cei the attendir	Physician/Me	in the past 12 months?	f yes, outcome of pregnanc 1□Live birth 2□Fetal de 4□Pregnant at time of deat 9□Unknown	eath 3	Ectopic pregnancy Other (specify)				23d. Date of de Month		ear ear
cords, r.	w requires that the death been signed by the atte should be detached for	by	Part II. Dther significant conditions contribu	uting to death but not resulti	ng in the un	derlying cause give	n in Part I.		tobacco Yes 2		to the cause of de	eath?
ב ב	The law re cate has bee page 2 sho	Completed						24a. Was auto perfo 1 Yes		24b. Were a prior to death?	utopsy findings a completion of ca s 2 \( \text{No} \)	vailable use of
<u> </u>	certific	Be	25. Was case referred to medical examiner?	ıtal:		Othe	-	eath (Check only				
	ling Phys I. After this funeral di	lon: To	27. Manner of Death 1 Datural 5 Pending	1   Inpatient 2   EH	VOutpatient 3b. Time of Injury	28c. Injury Work	at	Home 5 Resi			ecify)	
JIVISIC	or Attendation death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home building, etc. (Specify)	e, farm, stre		es 2 □ No	28f. Location ( City or To	Street a wn, Stat	nd Number or F le)	Rural Route Numb	79r,
_	To the Hospital or Attending Physician: The law within 24 buous after death. To the Funaral Director Atter this certificate has completely filled in by the funeral director, page 2	edical Ce	(Check only 2 Medical Examiner:	in: To the best of my knowle On the basis of examination and manner stated.	edge, death	occurred at the time estigation, in my opi	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s	s) and manner and place, and du	s stated. e to the cause(s)	
	To the To the compl	Me	29b. Signature and title of certifier	M	NI	29c. License	507a	25	29d. D	ate signed (Mor	th, Dey, Year)	(0
2	(8)		30. Name and address of person who compl				Cari La	204 M= 7			MT 2110	10
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 2 2006	32. Segistrar's Signatur		erans Hw	y Suite	204 M11	rers	sville,	MD 2110	10
	100		OF I T W TOOO	AND THE P	1							

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2006 Sept. 6, **Physician** Louis Goss 5:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, May 1, Birthplace (State or Foreign Country) **Funeral** 1<del>∏</del>M 2□ F Months Days Hours Min. 579-24-9183 80 Director Wash. DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits nem xr is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, if a Madical Examinar must be notified at 1√2 Yes 2 □ No Director MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 150 Chevy Chase Street # 406 20878 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XiYes 2 □ No WW II If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. Int: If Item 27 is marked other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pharmaseutical Corp. Elementary/Secondary (0-12) College (1-4or 5+) Directory Research and Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sol Gass Sonia Darman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Goss-Packard - Daughter 3007 Windy Knoll Court Rockville MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Its eny injury or ot once. 30 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 9.8.06 Clarksburg - MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Edward Sage I Funeral Direction Inc. 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9□ Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ል 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. ours after death.

nerel Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) D0062435 15027736 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weste Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) State 8 2006 Registrar

06-06556 Seymour Gordon Please Type or Print in Black Indelible Ink

		State of Maryland / Departm  1- For State Certific Registrar Certific	cate of				eg. No. 20	06 3019
Physici	an/	Decedent's Name (First, Middle,Last)				Date of Deat     Month     Septembe		3. Time of Death 2012 hrs
al Exami	iner	Seymour Gordon  4a. Facility Name (if not institution, give street and number)	<u> </u>	b. City, Town, or Lo	ecation of Dooth	Septembe	r 1, 2006 4c. County of De	
		St. Agnes Hospital		Baltimore	cation of Death		4c. Oddrity of Be.	aut
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min	-	1	Birthplace (State or eign
Director		579-18-9922   1XM 2 F   85	Yrs.	World S Days	riodis	5-11-1	.921	Country) NY
ž		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Locatio	n .		-		10d. Inside City Limits
1 10 w al		MD PrinceGeorge's West H						1 X Yes 2 No
filed within 72 hours after death with the Maryland 1 Hygiene ed other than "natural", or items 23a or 28a-f show any 1, the Medical Examiner must be notified at once.	cto	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Co	ountry?
or 28	Director	2513 Van Buren Street		20782		Ţ	J.S.A.	•
Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene in the ment of Heath and Mental Hygiene and in the man 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S.		Decedent of Hispa			14. Race - Am	erican Indian, Black,
r iten	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes	s, specify Cuban, N	Mexican, Puerto I	Rican, etc.)	White, etc.	ite
after ( al", o	by F	Widowed 4 N Divorced If Yes, Give Year WWII	1 \ \	Yes 2X No	specify:		Specify: W11	.Tte
nours	edt			s Usual Occupation st of working life. D			16b. Kind of Busines	s/Industry
permit. Pages   and 2 should be fried within 1.21 Department of Health and Mental Hygiene Important: If item 27 is marked other than "- injury or other traumatic event, the Medical E	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 2+	Incure	nce Sale	C	,	Insura	noo
giene Biene Sher tl	Completed	17. Father's Name (First, Middle, Last)	Insura			(First Middle M	Maiden Surname)	
tal Hy ked or	Be C	Raphael Gordon			Sara	"Unknow	,	
Men marl		19a. Informant's Name/Relationship (Type, Print )	9b. Mailing ،	Address (Street a	and Number or R		ber, City or Town, Sta	ate, Zip Code)
th and 127 is	8 14						le, MD 208	
f Hea If iten				ion (Name of ceme er place) e <b>moria</b> 1		Date	20c. Location - City	
ant:	Н	4 Donation Other Specify:	an Me	emoriai	9-4-	-06	Olney, M	Ш
epartn nport jury		21. Signature f neral Service Licensee				_		Direction
							ille, MD 2	
/sician ledical		2 a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.	not enter the	e mode of dying, su	ich as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
aminer	8 6	Immediate Cause (Final disease or condition resulting in death)  a. Chest injuries  Due to (or as a consequence of):				-		Death
		but to (or as a consequence or).						
	Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):						
	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):						
uted Id ansit	Ë	events resulting in death) Last  Due to (or as a consequence or):  d.						
n certificate be executed tending physician and use as the burial - transit	lica	UNPENDED AMENDED						
eath certificate be executed attending physician and for use as the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy	у				23d. Date of deliver	ery
ding se as t	sician/I	Description of death	- =		Ectopic pregnar	ncy	Month	Day Year
e atter	ysic	1 Yes 2 No 9 Unknown 9 Unknown	5 Othe	er (Specify)				
rife faw requires that the ucani cate has heen signed by the atte page 2 should be detached for u	Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the un	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
has heen signed by 2 should be detach	d by					1 Yes	2 No 3 P	robably 4 Unknown
heen	lete					24a. Was a		autopsy findings available o completion of cause of
te has	Completed					perform	med? death'	?
	ပို	25. Was case referred to medical		26. Place of	Death (Check o	Command .		163 2 110
this ce	e e	examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 V ER/0	Outpatient	3 DOA	ther Nursing	Home 5	Residence 6 Oth	ner:
After i uneral	l :	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b	. Time of Inj	jury 28c. Injury			ow injury occurred	
feath. tor: , the f	atio	1 Natural 5 Pending Sep 1, 2006 188	53 hrs	1 Ye	s 2 🗸 No	Jilvei auto a	auto comsion	
Hospital of Attending ripsician: 24 hours after death. Funeral Director: After this certifiely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home,		, factory, office buil	ding, etc.	28f. Location (S or Town, St		Rural Route Number, City
24 hours after death Funeral Director: tely filled in by the	Cer	4 Homicide determined (Specify) Major Road / H	lighway		1 9	9590 North I	_aúrel Road, Lau	urel, MD
within 24 h To the Fun completely		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or						
무도무법	Medical	29b. Signature and title of certifier	songano	29c. License		unio, date a	29d. Date signed (A	· · · · · · · · · · · · · · · · · · ·
To the within 2 To the complet	2	A C V 1		O.C.M			September 2, 2	
wit To								
<b>3 2 3 3 3 3 3 3 3 3 3 3</b>		Pamer Fietray, M.						
5 Page 1		30. Name and address of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner		enn Street, Ba		21201		

#### 06-06630 David Galukenhous

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar		Certif	icate of	Death			Reg. No.	200	6 3019
Physician	E/	1. Decedent's Name (First, Middle	•					Date of I    Month	Day	Year	3. Time of Death 1508 hrs
Medical Examine		David Glukenh		_		In City Toyen or	· Loopling of		ber 4, 200	06 County of Death	1506 Hrs
		4a. Facility Name (if not institution Suburban Hospital	n, give street and number	er)	ľ	lb. City, Town, or Bethesda	Location of	Death		ntgomery	
- Francisco	4		6. Sex 7. A	Age (In yrs. last	hirthday)	If Under 1 Yea	ar If Under	24Hrs 8 Date of		D/YYYY) 9. Birth	nolace (State or
Funeral Director						Months Day		Min.		Foreign	District of
	-	578-52-6881 Usual Residence of Decedent	1 M 2 F	65	Yrs			09/	30/1940		<sup>intry)</sup> Columbia
á	<u> </u>	10a. State 10b. County		10c. City, To	wn or Locati	on			-		10d. Inside City Limits
p wow i		Maryland Montgo	merv		Ro	ckville					1 Yes 2 X No
nrylan 8a-f sl	왌	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Coun	try?
or 28	Director	6121 Montrose Ro	and			208	0.50			II 0 4	
with t	ᇹ	11. Marital Status	12. Was Decede	nt Ever in U.S.		s Decedent of Hi	spanic Origir	n? ( Specify Yes or	No- 14	U.S.A. 4. Race - Americ	an Indian, Black,
eath ritem	Funeral	1 X Never Married 2 Ma	rried Armed Force	s? 2 🗓 No	If Y	es, specify Cubar	n, Mexican, f	Puerto Rican, etc.)		White, etc.	
fter d		3 Widowed 4 Divo	orced If Yes, Give Year	2 23 140	1	Yes 2X No	specify:		S	pecify: Ca	ucasian
ours a atura camin	g P	15. Decedent's Education (Spec		ompleted) 16		st of working life			16b. Kin	nd of Business/In	ndustry
5 72 h cal E	Completed	Elementary/Secondary (0-12)	College (1-4 o	or 5+)	during m	ost of working me	s. DO NOT u	se retired)			
within sene en the	틹		2		St	ore Clerk	_			Private	
Hyggen the		17. Father's Name (First, Middle,	•					Name (First, Midd		ırname)	
12'd be de larke event	8	William Glu 19a. Informant's Name/Relationsh			10h Mailing	Address (Stra		Frances She per or Rural Route		or Town State	Zin Code)
D 2 shoul and N 7 is n	٥	David Forseter -			7	•					
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mantal Hygueries of Health and Mantal Hygueries and "natural", or items 23a or 28a-f she in the firem and the near the Medical Examiner must be notified at once or the most of the firem and the notified at once of the firem of the firem and the notified at once of the fireman and the most of the fireman and the fi	ŀ	2Ca. Method of Disposition	rersonar kep	20b. Plac	ce of Dispos	tion (Name of ce		Date		cation - City or T	y1and 20814 Town, State
Ore ges 1 t of H t . If i	1	1 X Burial 2 Cremation	3 Removal from	Jiaie	matory or oth				ŀ		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any important: If item 27 is marked other than "natural", or items 23a or 28a-f show any important: If item 27 is marked other than "natural", or items 23a or 28a-f show any important of the Medical Examiner must be notified at once.	+	4 Donation 5 Other Sp. 21. Signature of Funeral Service I		Elesa		1 Cemetery ame and Addres		9/16/2006		hington, l	
Baltin permit Departm Importa	-		Colert		- 1			Hines-Rin			e, Inc. ryland 20904
Physician	+	23a. Part I. Enter the disease, or o	complications that cause	ed the death, Do	not enter ti	ne mode of dvina	, such as car	rdiac or respiratory	arrest, shock	, or heart	Approximate Interval
/Medical		failure. List only one cause of Immediate Cause (Final disease	on each line. Cardi a and Hyper	ac arrhyt tensive A	chmia a Atheros	ssociated Terotic (	with Si ardiova	ick Sinus S escular dis	yndrome ease	3	Between Onset and Death
7.xaminer	-	or condition resulting in death)	Due to (or as a cor		1010100	21010010	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	iocaiai aio	<u> </u>		
•		Sequentially list conditions,	b								
	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):							
			d								
be exe	/Medical	X UNPENDED	X AMENDED	ten#1,23a	1,27,pe	iΈ,gου,	10/11/0	6 TT			
68760, certificate be nding physicials as the buri	Š.	IF FEMALE:	23c. If yes, outo	ome of pregnar	ncy					Date of delivery	V
certif certif anding use as	Siar	past 12 months?	e 1 Live birth 4 Pregnant	at time of death		tal death 3 ner (Specify)	Ectobic	pregnancy		Ionth Da	ay Year
Box 68 e death certif	Physicial	1 Yes 2 No 9 Unk	nown 9 Unknown		٥ <u> </u>	iei (Opeciny)			100		
		Part II. Other significant condition	ons contributing to de	ath but not resu	Ilting in the u	nderlying cause	given in Part	t I. 23e. D	id tobacco us	e contribute to the	he cause of death?
rres th	d b							1	Yes 2	No 3 Proba	ably 4 🗹 Unknown
requirements	Completed							24a. W	/as an utopsy		opsy findings available ompletion of cause of
eco he law te has	E C							p	erformed?	death? 1 ✔ Yes	
LI R		25. Was case referred to medical				26.Plac	e of Death (0	Check only one)			
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2 🗸 EF	R/Outpatient	3 DOA	Other <sub>4</sub>	Nursing Home 5	Residenc	ce 6 Other:	
Division of Vital Records, P.O. ra or Attending Physician: The law requires that the ras after death all Director: After this certificate has been signed by led in by the timeral director, page 2 should be detached in by the timeral director.	=	27. Manner of Death	28a. Date of I (Month, Da		Bb. Time of I	njury 28c. Inju	ury at Work?	28d Descr	ibe how injury	occurred	
itendi leath tor: ,	탏	1 A Natural 5 Pend 2 Accident Inves	ing tigation			1_	Yes 2	No			
or Al after of Direc	띭	3 Suicide 6 Could	not be 28e. Place of	Injury - At home	e, farm, stree	et, factory, office	building, etc.		on (Street and n, State)	Number or Rur	al Route Number, City
Spital Spital nours nours filled	Certification:	4 Homicide	mined (Specify)				_	- 10			
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	g	Chicon only	ysician: To the best of miner:On the basis of e								
To the within To the comple	Medical	29b. Signature and title of certifier	and manner state			29c. Licen:				ate signed (Mon	
		On o A P	4/00 0	0 00			.M.E.			ember 6, 200	
	ļ		1700		201				Jopie		
		<ol> <li>Name and address of person Carol Allan, MD Ass</li> </ol>	who completed cause of sistant Medical Ex		,	Street, Baltim	nore, MD	21201			
Sta	ate	31. Date filed (MSEP), Ta'9	2000 32 Regis	trar's Signature	Spa						
Registr	rar	3EF 19	2000 Head	NEN ST.	PSTONE						

			For State Registrar	State of Mary	-		of Health and of Death	R	eg. No. ZUU	6 30194
ŧ	Physici	an	1. Decedent's Name (First, Middle, La  Lois E	st) lizabeth	Gloss			2. Date of Deal Month Septemb	pay Yeer 200	3. Time of Death  4:15 A M
3	/Medic Examin		4a. Facility Name (If not institution, giv		GIOSS	4b. City, 7	own, or Location of Deat		4c. County of Dea	
	LAGITIII	-	2790 Plum Point	Road		Hunt	ingtown		Calver	t
	Funeral Director		5. Social Security Number 6. S 220–34–3982	Sex 7. Age (// 1 □ M 2 🛱 F 88	yrs. last birthday) Yrs.	If Under Months			Year) C	rthplace (State or Foreign Country)
	P.		Usual Residence of Decedent		0.5 T					and Inside City Limits
	72 hours after death with the Maryland natural; or items 23a or 28a-f ehow iteal Examinar roust be notified at	tor	MD County Calvert	1	c. City, Town or L		ingtown			10d. Inside City Limits 1 ☐ Yes 2 No
	r 288	Director	10e. Street and Number			10f. Zip	Code	1	0g. Citizen of Whal C	Country?
	th wit		2790 Plum Point	Road			20639		USA	
	ens La	Funerai	11. Marital Status	12. Was Decedeni Eve Armed Forces?	r in U.S. 13.	Was Decede	ent ol Hispanic Origin? (S fy Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
215-0036	urs afte al', or it Examin	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		1 ☐ Yes 2			Specify: W	hite
O O	72 ho	ted	15. Decedent's E		16a. Dece	dent's Usua	Occupation	rkina	16b. Kind of Busines	s/Industry
	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		omemak	k done during most of wo e retired)	,,,,,,g	own hom	ne
0	e filed v Il Hygie other t	BeC	17. Father's Name (First, Middle, Last	)				me (First, Middle,	Maiden Sumame)	
a		To B	Walter Robert	Hays				Anna	Ī	horne
Maryland 21			19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ing Address	(Street and Number or R	ural Route Number	; City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Donann Gloss Se	idel, daught	er 279	O Plum	Point Road	, Hunting	gtown, MD	20639
altimore,			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐		20b. Place of Dispo cemetery, cre	osition (Nam matory or ot	ne of her place)	Date	20c. Location - City o	r Town, Slate
Ĕ	Pages nent of ent: if it ury or o		4 □Donation 5 □Other (Speci	fy)	Metropol:	itan C	rematory 9-	6-2006	Alexandri	a, VA
Balt	permit. Page Department importent: if any injury or once.		21. Signature of Funeral Service Lice	2 Gras			d Address of Facility  Funeral Ho	me. P.A.	. Owings.	MD 20736
			23a. Part1. Enler the disease, or com shock, or heart failure. List only	pplications that caused the						Approximate Interval Between
· ·	Physician		Immediate Cause (Final disease or condition	Coros	0.04	ante	ry disea	20.		Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of):	-(1 10	7 0 30 0	<del>,,</del>		ora year
	Examiner		Sequentially list conditions,	b	·					
	D #	ner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	unaquence of.					
	ecute Ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c						
60,	icate be executed physician and s the burial-transit		Todaling in dodain, Eddi	Due to (or as a c	onsequence or);					
68760,	icate physics the	edical		d					-	
_	eath certif attending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Date of de	elivery
P.O. Box	sattendin for use	Physician/M	in the past 12 months?  1  Yes 2 No	1□Live birth 2 [ 4□Pregnant at tim		□Eclopic pre □ Other (spe			Month	Day Year
o.	t the c	hys	9 Unknown	9□ Unknown					-0	
	law requires that the death certifes so been signed by the attending 2 should be detached for use a	Ď	Part II. Other significant conditions	contributing to death but n	ot resulting in the t	underlying ca	ause given in Part I.	23e. Did to	10	to the cause of death?  Probably 4 Unknown
Ö	w require been si should t	ete						24a. Was a	n 24h Were	autopsy findings available
He e	The lay	Completed						autop: perfor	ned? prior to death?	completion of cause of
æ		ပို	25. Was case referred to medical			7.	36 Place of De	1 ☐ Yes ath (Check only or	-	es 2 No
5	s cert	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1   Inpatient	2 ER/Outpatie	enI 3□ DO	Othor	0,000	ence 6 □Olher (Sp	necify)
Division of Vital Records,	or Attending Physician: after death. Director: After this certifice in by the funeral director, i		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	28b. Time o	of 2	Bc. Injury al Work?		ow injury occurred	odiy)
Sic	tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not t		Al homo form of	M Issat factors	1 Yes 2 No	28f Location (S	treet and Number or F	Pural Pouta Number
Σ	= = = -	Certification:	4 Homicide determined	building, etc.		rieet, ractory	, office	City or Tow	n, State)	TUTAL FIGURE FUNDOS,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of n miner: On the basis of ex and manner stated	amination and/or in	th occurred anvestigation,	at the time, date and place in my opinion, death occ	e, and due to the curred at the time, d	ause(s) and manner a late and place, and di	as stated. ue to the cause(s)
	ompli	Me	29b. Signature and title of certifier			29c	. License number	2	9d. Date signed (Mor	nth, Day, Year)
	- s - ō		1 Clarales	Bennett 1	110	D2	5156	5	September	5, 2006
•			30. Name and address of person who							•
	10		Charles W Benr				eman Road.	Lusbv MD	20657	
	Sta		31. Date filed (Month, Day, Year) SEP	32. Registra	Signature					
3	Regist	eli	011	I MUUUP A	CONTRACT AT	Link	402 11			

		1 - State Registrar	State of Maryla	Cei	rtificate of	Death		Reg. No.	- 0 0 0	301
h		1. Decedent's Name (First, Middle, Last	)				2. Date of De	ath Day	Vear	3. Time of Death
hysicia /Medic		Alice Kilby Grin	sted		_		Septem	ber 2,	2006	10:46 A
xamin	er	4a. Facility Name (If not institution, give				or Location of Death			unty of Death	
		Calvert County Nu 5. Social Security Number 6. Se		s. last birthday)		Frederick  If Under 24 Hrs.		1	vert C	
neral ector			<sup>2</sup> M <sup>2</sup> X F 76	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Nov • 2	3, 192	9. Birthi Coul Mar	place (State or Fore ntry) yland
a ta		10a. State 10b. County	10c. (	City, Town or Lo	cation				Τ,	10d. Inside City Lim
fled	ţ	MD Calvert C	County	wings						1 ☐ Yes 2- 1
2	irec	10e. Street and Number	, , , ,		10f. Zip Code			10g. Citizen	of What Cou	ntry?
4	ai	6245 Earl Street			20736			U.S	S.A.	
in the	Funeral Director	11. Marital Status	<ol><li>Was Decedent Ever in Armed Forces?</li></ol>	U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14.	Race - Americ Black, White,	
i i	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	1 ☐ Yes 2 🐧 No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:				hite
E E	9	15. Decedent's Edu	Year or Dates:	16a Decer	dent's Usual Occup	ation		16h Kind	of Business/le	duate.
Aedic	Completed	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retired	during most of wor	king	166. King (	of Business/In	idustry
1	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Acco	unt Adjus	ster		Gas	& Ligh	t Company
troil of a marked other than induced, or tells out to positive other treumatic event, the Madical Examiner count be notified at	BeC	17. Father's Name (First, Middle, Last)		*		18. Mother's Nan		Maiden Sur	mame)	
tice	To B	James Kilby				0seco1	a Arnal			
E .		19a. Informant's Name/Relationship (Ty	vpe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or To	wn, State, Zip	Code)
ther tr			ughter)		Earl St	reet, Owi	ngs, Ma	-		
or of		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, cren	osition (Name of matory or other place	Sept	Date	20c. Locati	on - City or To	own, State
eny injury or of		4 ☐ Donation 5 ☐ Other (Specify)	Wa	shingto	n Nat. Ce	em.	2006	Suitl	and. M	aryland
ny in		21. Signature of Prince Licens	88	22	2. Name and Addre	ss of Facility Le	e Funer	al Hom	e Calv	ert, P.A.
• a		23a. Part1. Enter the disease, or compl	4		125 South				wings,	MD 2073
ician dical niner		Immediate Cause (Final disease or condition resulting in death)	a. MULTIORGI Due to (or as a conse		LURE DU	IE TO D	EMENT	A		YEARS
	cai Examiner	Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.	,,	or eye.					
the burial-transit	dicai	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	equence of):  nancy tal death 3	□Ectopic pregnancy	,		23d.	Date of delive	ery Day Year
be deteched for use as the burial-transit	by Physiclan/Medicai	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a consect.)  Due to (or as a consect.)  Consecutive birth 2 Fe 4 Pregnant at time of 9 Unknown	nancy tal death 3 death 5	Other (specify)	-	23e. Did to	obacco use c	Month	Day Year
hould be deteched for use as the burial-transit	by Physiclan/Medicai	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consect.)  Due to (or as a consect.)  Consecutive birth 2 Fe 4 Pregnant at time of 9 Unknown	nancy tal death 3 death 5	Other (specify)	-	101	obacco use c	Month contribute to the	Day Year The cause of death?  Pably 4 □Unknown
hould be deteched for use as the burial-transit	Physician/Medicai	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consect.)  Due to (or as a consect.)  Consecutive birth 2 Fe 4 Pregnant at time of 9 Unknown	nancy tal death 3 death 5	Other (specify)	-	1 🗆 Y	obacco use c	Month contribute to the autoprior to condeath?	Day Year  ne cause of death?  pably 4 □Unknown  psy findings availal
hould be deteched for use as the burial-transit	Be Completed by Physician/Medical	if any, leading to denergying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)  Cac. If yes, outcome of pregners to the consect.  Due to (or as a consect.)  The consect to the consect.  Due to (or as a consect.)  The consect to the consect.  Due to (or as a consect.)  The consect to the consect.  Due to (or as a consect.)  The consect to the consect.  Due to (or as a consect.)  The consect to the consect.  Due to (or as a consect.)  Due to (or as a	nancy tal death 3 death 5	Other (specify)	en in Part I.	24a. Was autop perfo 1 Yes	obacco use co/es 2/2/No	Month contribute to the autoprior to condeath?	Day Year  ne cause of death?  pably 4 Unknown  psy findings availal  mpletion of cause of
director, page 2 should be deteched for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to merediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions conditions conditions? 1 □ Yes 2 ☑ No	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Cac. If yes, outcome of pregners to the pregnent at time of a supplied to death but not respond to the pregners of the pregne	nancy tal death 3 death 5 sulting in the un	Other (specify)	en in Part I.  26. Place of Dea er: 4  Nursing He	24a. Was autop performent of the Check only or onne 5 🗆 Resident experience of the Check only or onne 5 🗀 Resident experience of the Check on the	obacco use c /es 2//No an 24 sy rmed? 2//No	contribute to the autoprior to cordeath?	Day Year  ne cause of death?  pably 4 Unknow  psy findings availal  mpletion of cause of
director, page 2 should be deteched for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions conditions are referred to medical examiner? 1   Yes 2   No   Yes   Due to (or as a consect of the conse	nancy stal death 3 death 5	Other (specify)	26. Place of Dea er: 4 🕅 Nursing Hoy at k?	24a. Was autop performed to the Check only of the Check on Check o	obacco use c /es 2//No an 24 sy rmed? 2//No	contribute to the autoprior to cordeath?	Day Year  ne cause of death?  pably 4 Unknow  psy findings availal  mpletion of cause of	
director, page 2 should be deteched for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  The property of the property	nancy tal death 3 death 5 sulting in the un	Other (specify)  Inderlying cause give  Int 3 □ DOA Cthe    28c. Injun   Word   M 1 □	en in Part I.  26. Place of Dea er: 4  Nursing He	24a. Was autop performent of the Check only of t	obacco use c /es 2/No an 24 sy med? 2/No ne dence 6 10 street and No	contribute to the analysis of the autoprior to condeath?  Other (Specifications)	Day Year  ne cause of death?  pably 4 Unknown  psy findings availa  mpletion of cause of  2 No
director, page 2 should be deteched for use as the burial-transit	Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  I Due to (or as a consect.)  Due to (or as a consect.)  I Due to (or as a consect.)  Due to (or as a consect.)  I Due to (or as a consect.)  Due to (or as a	nancy tal death 3 death 5 sulting in the ur  ER/Outpatien 28b. Time of Injury  home, farm, stresify)	other (specify)  nderlying cause give  at 3 □ DOA	26. Place of Dea er: 4⊠ Nursing He y at k? Yes 2 □ No	24a. Was autop performent of the Check only of t	obacco use of the state of the	Month contribute to the contri	Day Year  The cause of death?  Dably 4 Unknow  Dably 4 Unknow  Day findings availate  Proposition of cause of cause of cause of death?
director, page 2 should be deteched for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions condition	Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consec	nancy tal death 3 death 5 sulting in the ur  ER/Outpatien 28b. Time of Injury  home, farm, stresify)	other (specify)  nderlying cause give  at 3 □ DOA	26. Place of Dea er: 4⊠ Nursing Ho y at k? Yes 2 □ No	24a. Was autop performent of the Check only only only only only only only only	obacco use of the symmetry of	Month contribute to the contri	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?
led in by the funeral director, page 2 should be deteched for use as the burial-transit	Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  I Due to (or as a consect.)  Due to (or as a consect.)  I Due to (or as a consect.)  Due to (or as a consect.)  I Due to (or as a consect.)  Due to (or as a	nancy tal death 3 death 5 sulting in the ur  ER/Outpatien 28b. Time of Injury  home, farm, stresify)	Other (specify)  Inderlying cause give  Inder	en in Part I.  26. Place of Dea er: 4⊠ Nursing Ho y at k? Yes 2 □ No ne, date and place, pinion, death occur e number	24a. Was autop performent of the Check only only only only only only only only	obacco use of the state of the	Month contribute to the contri	Day Year  Day Year  The cause of death?  Dably 4 Unknown  Day 4 Unknown  Day 4 Unknown  Day 4 Unknown  Day 4 Unknown  Day 4 Unknown  Day 4 Unknown  Day 6 Unknown  Day 6 Unknown  Day 6 Unknown  Day 6 Unknown  Day 7 Unknown  Day 7 Unknown  Day 7 Unknown  Day 7 Unknown  Day 7 Unknown  Day 7 Unknown  Day 7 Unknown  Day 8 Unknown  Day 8 Unknown  Day 9 Un
director, page 2 should be deteched for use as the burial-transit	Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)  I Live birth 2   Fe	nancy tal death 3 death 5 sulting in the undeath 28b. Time of Injury  home, farm, streatify)	other (specify)  Inderlying cause give  at 3 DOA Cth  28c. Injun  Word  M 1 = eet, factory, office  a occurred at the tim vestigation, in my office  29c. License  D 4	26. Place of Dea er: 4⊠ Nursing Ho y at k? Yes 2 □ No	24a. Was autop performent of the Check only only only only only only only only	obacco use of the symmetry of	Month contribute to the contri	Day Year  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?  The cause of death?

State of Maryland / Department of Health and Mental Hygiene. Reg. No. 2006 30196 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thelma Edna Gertz sept 1 2006 1055 A<sub>M</sub> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 79 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign Country)
1927 Pennsyl.vana 6. Sex **Funeral** Months 1 ☐ M 2 🖫 F 191-20-3649 Director April Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ast be rutified at Lusby Calvert Maryland 1 ☐ Yes 2 No Director 10f. Zip Code 20657 10e. Street and Number 10g. Citizen of What Country? United States ŏ 259 Frontier Trail or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status traumatic event, the Madical Experiment 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If itam 27 is marked other than any injury or other traumatic event, Italy once. Security Co. office Administrator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Anne Cepris Be Ernst Grimm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 259 Frontier Trail Lusby MD 20657 Albert E. Gertz- husband 20b. Place of Disposition (Name of cometery, crematory or other place)

Maryland Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 2006 Cheltenham Maryland 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** disease or condition resulting in death) lower Love pullumonia /Medical Examiner Ovarian Scuentially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit hab and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b: Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 Yes 20 No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA this 27. Man of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation Injury Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: / 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide in 24 hours.
the Funaral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20060475 MD 30. Name and address of person who completed cause of death (It m 23a) (Type, Print) 19) MD HOSPITAL ROAD, PRINCE FREDERICK MD 20678 (00 BUCH 31. Date filed (Month, Day, Year) 32. Registra Signature State SEP 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Sept. 13, 2006 Louise Y. Govans 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 827A Windstream Way Harford Edgewood Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 21, 1 6. Sex Days 1□M 2ŪF 207-26-2194 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 € Yes 2 No Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 827A Windstream Way USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ⊠Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ing most of working Elementary/Secondary (0-12) College (1-4or 5+) Administrative Aid Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Andrew Clarkson Young Nettie Rebecca Mae Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7168 Glen Meadow Ct. Frederick, MD 21703 Ronald Govans/Son 20b. Place of Disposition (Name of cometery, crematory or other place)
St. James United 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 2006 Jarrettsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.J. Hartenstein Mortuary 19 S. Main St., Stewartstown, PA 17363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest

Physician /Medical Examiner

permit.
Departn
Imports
any inju

**Physician** 

Examiner

**Funeral** 

Director

with the Maryland

Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar nent of Health and Mental Hygiene. san: If item 27 is marked other then "natural", or itams 23a or 28e-f show ury or other treumatic event, the Medical Examinar must be notified.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Directo

Completed by Funeral

Be ၉

ed by the attending physiclen end detached for use es the burial-transit nerel Director; A filled in by the fu

The law requires that the death certificate be executed

el or Attending Physician: after death.

To the Hospitel o within 24 hours aft To the Funerel D completely filled in

Division of Vital Records, P.O. Box 68760,

	shock, or heart failure. List only o	ne cause on each line.	4. 0		/	Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. <u>Metastatie</u> Due to (or as a consequ		all lell lames	I lungs	less then
ıminer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse a	ence of):			
IIcal Exa	resulting in death) Last	Due to (or as a consequ	ence of):			
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 □Ectopic			23d. Date of delivery Month Day Year
ed by Pi	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the underlying	cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Complet					24a. Was an autopsy performed?	
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 8	ER/Outpatient 3□ D	OA Other: 4 Nursing I	Home Hesidence	6 ☐Other (Specify)
atlon;	27. Manner of Death  Natural 5 Pending  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred
Medical Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
edical	29a. Certifying Physical (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	viedge, death occurre ion and/or investigatio	d at the time, date and place, in my opinion, death occ	e, and due to the cause( urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
ž	29b. Signature and title of certifier		29	c. License number	29d. D	ate signed (Month, Dev. Year)

50040

29d. Date signed (Month, Dey, Year)

09,13,2006

21040

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEP 2

2006

32. Redistrar's Signature

		•	1 - State of Maryland / De State of Maryland / De Registrar	epartment of Health and N Certificate of Death	1ental Hygie Reg		30198
126	D)		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Sidney Clarence Hart		SEPTEMBE	E124 2006	5-30 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
L			St. Thomas More Nursing Home	Hyattsvil Hyattsvil Hyattsvil		Prince	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo		lace (State or Foreign try)
	Director	}	578-60-6432 59 Yr Usual Residence of Decedent	·	July 7,	194/   Was	h., DC
	land		10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Limits
	Many f sh	ō	DC	Washington			1 XYes 2 No
	28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	ntry?
	38 o		2910 - 13th St., NW	20009		United S	tates
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	an Indian,
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic evant, Ite Medical Example in usit to notified at any injury or other traumatic evant, Ite Medical Example.	by Fu	1 Never Married 2 Married 1 Yes, Sive 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	nicali, etc.)		lack
	2 hou	ted	15. Decedent's Education 16a. D	ecedent's Usual Occupation	16	b. Kind of Business/Inc	dustry
7	hin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work ife. DO NOT use retired)	ing		
V	er the	TO.	3	Social Worke	r	Priva	te
מום	al Hy al Hy 1 oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	iden Sumame)	
<u>a</u>	Ment Ment arkad atlc	2	Clarence Hart		Alice	e Leary	
a	and and ls my			Mailing Address (Street and Number or Rui			Code)
e, E	and lealth m 27 her tr			714 Ely Place, SE V		20019	State .
0	ges 1 t of H If Ite or of		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	crematory or other place)		c. Location - City or To	wn, State
Saltimor	tmen tent: jury			Memorial Park 9/8/2		Landover	, MD
o O	Depariment Department of the series of the s		21. Signature of Egneral Service Licenses	22. Name and Address of Facility States 4001 Benning Rd		neral Home	11.0
			23a Part 1 After the disease or complications that caused the death. Do no			sh., DC 200	Approximate
			23a. Part 1. Inter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	( ( )			Interval Between Onset and Death
)	Physician /Medical		resulting in death)	eal sonsis			week
	Examiner		Due to (or as a consequence of	).			
		ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	):			
	outed d ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events  C				
Ď	an ar		resulting in death) Last Due to (or as a consequence of	):			
09/89	death certificate be executed e attending physician and id for use as the burial-transit	edicai	d				
õ	ing ph	Med	IF FEMALE:				
X D	ath ce ttend	an/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delive Month	ny Day Year
5	the a	Physician/M	1   Yes 2   No 9   Unknown 4   Pregnant at time of death	5 Other (specify)			
7	w requires that the death certif been signed by the attending should be detached for use a:		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I	23e. Did tobac	cco use contribute to the	ne cause of death?
as,	signe signe	l by				/	ably 4 □Unknown
Š	requipe people	etec	End State Ronal Diters		040 1400 00	Ton W	
7	sicien: The law certificate has b irector, page 2 s	ompieted	that Tropp romal Distrib	<u> </u>	24a. Was an autopsy performed	prior to cor death?	psy findings available npletion of cause of
_ 		O			1 Yes 2 €		2 No
VII	Physicien: r this certific ral director,	Ве	25. Was case referred to medical examiner?  1   Yes 2   No		h (Check only one)		
ō	Phy r this aral d	To	27. Manner of Death  28a. Date of Injury (Month, Day Year) Injury		28d. Describe how	e 6 Other (Specify	/)
0	th. : Afte	itior	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inj 2 ☐ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	or Attending Phys after death. Director: After this in by the funeral di	ifice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		et and Number or Rura	l Route Number,
5	el or A s after el Direc	Certification:	4   Homicue Building, etc. (Specify)		City or Town, S	otate)	
	To the Hospitel o within 24 hours aff To the Funerel D completely filled in	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and/and manner stated.				
	Nithin Onthi	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month,	Day, Year)
	- 7 - 0		MAR OR Corporation	L DO1852	_ Se	PTEMBER	2006
	0 (4)		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)		Ex. 1079	
1	0		Paul A. DEVORE MDY	203 QUEENSBURY	d Huat	tsville M	1207P1
	Sta		31. Date filed (Month, Day, Year)  SEP 1 2 2006				
	Reaistr	ar	TENTO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO ANTONIO				

		1 - State Registrar	State of Marylar	nd / Depa <i>Ce</i>	artmer <i>rtifica</i>	nt of He te of D	ealth an Death		Reg. No		3019
Physic	ian	Decedent's Name (First, Middle, Last)     Dorothy	Но	1.				2. Date of D Month	Da	y Year	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give s		IL	4b. City	Town, or I	Location of D			2, 2006 County of Deat	4:38 P M
Exami	ner	Washington Adven				ma Pa				ntgomery	
Funeral Director			7. Age (In yrs.	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 I Hours N	8. Date of B (Month, D) 3/10/1	irth ay, Year) <b>924</b>	9. Birti Co <b>Was</b> l	nplace (State or Foreign untry)
anyland show	ត់	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Geo		ty, Town or Lo		s					10d. Inside City Limits 1 X Yes 2 □ No
the h	rect	10e. Street and Number			10f. Zi	p Code			10g. Ci	tizen of What Co	untry?
h with	Ö	5727 Eagle Street				747			Unit	ed State	es
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Examinar marks inclined at mone.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes	cify Cuban	panic Origin's, Mexican, Pi	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ame Black, White Specify <b>B1ac</b>	e, etc.
21215-0036 d within 72 hours aff gione. er than "natural", or , the Medical Exprol	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			kind of we DO NOT L	ork done du ise retired)	tion uring most of	working		(ind of Business/	Industry
Hygie out, the	င္ပေ	17. Father's Name (First, Middle, Last)		Home	шакет		18. Mother's	Name (First, Middle		ivate	
Maryland Id 2 should be file Ith and Mental Hy, Ith is marked othe treumatic event,	To Be	Alphonso Lacey						Lie Griff	•	,	
shour should will be mark	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Addres	s (Street a	nd Number o	r Aural Route Numi	ber, City	or Town, State, 2	Tip Code)
and 2 selth and 2 n 27 i		Pattie Herndon / Da	•	10904	4 Tra	fton	Drive,	Upper M	arlb	oro, MD	20744
Pages 1 Pages 1 nent of He nut: if ite		20a. Method of Disposition  1 N Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State	Place of Dispondering Comments of Dispondering Comments of Comment	matory or	other place		Date L1/2006		ocation - City or i	Town, State  Maryland
Baltimore, permit. Pages 1 ar Depertment of Hee importent: if item eny injury or othe		21. Signature of Funeral Service License	+	1	Pope	nd Address Fune	of Facility	omes, P.A	•		
Physician		23a. Part1. Efter the disease, or complishock, heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the dea					Pike, For diac or respiratory		TITE MD	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consec Chronic Ren	quence of): al Fai	lure						
ecuted end -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Congested Ho	eart Fa	ailur	e					
18760, cate be executed physicien end the burial-transit	dical E	L.	f.	quence on.							
P.O. BOX 6 that the death certific ed by the ettending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3[	⊒Ectopic p ⊒ Other (s					23d. Date of deli Month	very Day Year
rdS, P. quires that to a signed by ald be detailed.	d by Ph	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying	cause give	n in Part I.	1	tobacco	_	the cause of death?
Division of Vital Records, P. or Attending Physicien: The law requires that after death.  Director: After this certificate has been signed b in by the funeral director, page 2 should be deta	Completed							24a. Wha auto peri 1 □ Yes	opsy formed?	prior to death?	topsy findings available completion of cause of
On Of Vital Ho ding Physicien: The h. After this certificate h funeral director, page	Be (	25. Was case referred to medical examiner?	Indiana.					Death (Check only	one)		45 -45
Physic this c	2	1 ☐ Yes 2 No  27. Manner of Death		ER/Outpatier			4 Livuisit	ng Home 5 ☐ Res			city)
Attending I really.	ation	1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	м	28c. Injury Work: 1 □ Y	at ? es 2 □No	28d. Describe	now inju	iry occurred	
DIVISION TAND TAND TO A THE OF	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	reet, factor	y, office			(Street ar		ral Route Number,
DIVI  To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Examination (Check only one)	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred evestigation	at the time n, in my opi	e, date and pi inion, death o	lace, and due to the occurred at the time	a cause(s , date an	) and manner as d place, and due	stated, to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		1	29	c. License	number		29d. Da	ite signed (Monti	n, Day, Year)
				-	3	5826			9/3/	/2006	
2/3)		30. Name an laddless of person who co				ue. T	akoma	Park, MD	209	912	
St Regis	ate	31. Date filed (Month, Day, Year) SFP 1 2 2006	62. Registrar's Sign		No.	<b>,</b> -					

State of Maryland / Department of Health and Mental Hygiene, 30200 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day 8,\_ 2006 10:06<sup>a</sup> M Doxy J. Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges Hospital Chevelly

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Day, You
June 9, Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ,1936 Halifax, VA 231-38-3920 XXM 2 F 70 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-fehow the Medical Examiner must be notified at D.C. Washington 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 616 Tewkesbury Place, N.W. 20012 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itema 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Hydro Conduit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 le marked oth eny injury or other traumatic event once. Be Jack > В. Mary Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve A. Holt Wife 616 Tewkesbury Pl.N.W.Wash.D.C.20012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Fort Lincoln Cem 9-15-06 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA FATAL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2.20 No 1 ☐ Yes 2 ☐ No 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2X No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) WENDELL PIERSON 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 1 2 2006 Registrar

			1 - For State Registrar	State	of Ma	ryland				ealth a Death	and M		Reg. Not		06	302	01
	Dhyaiai		1. Decedent's Name (First, Midd.	e, Last)								2. Date of De Month	ath Day	,	Year	3. Time of De	aath
	Physici /Medio		Kathleen Anne	Smarey	Hamr	nett						Septer				10:10	ρм
	Examir		4a. Facility Name (If not institution	n, give street and	number)			4b. City,	Town, or	Location o	of Death		4c.	County	of Death		
			17026 Hersper	ger Lane						Poole	svil	16			Mont	gomerv	
	Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. la	ast birthday)	If Under	r 1 Year	ff Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th Year)		9. Birthp	lece (State or Fitry)	oreign
	Director		577-84-7251	1 □ M 2 € F	F	51	Yrs.	WOTHERS	Days	Hours		Jan. 14		₹55		land	
	<b>D</b> .		Usual Residence of Decedent														
	how i		10a. State 10b. County			10c. City	, Town or Lo	cation							1	0d. Inside City I	
	Man Park	cto	Maryland M	ontgomer	У			Pool	esvi	11e						1 ☐ Yes 25	<b>₹</b> INo
	17 28 P. 10	Directo	10e. Street and Number					10f. Zig	Code				10g. Citi	zen of \	What Coun	try?	
	23a (	aiD	17026 Hersperg	er Lane						2083	7				USA		
	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f ehow dical Examinat must be notified at	Funeral	11. Marital Status	12. Was D	ecedent E Forces?	ver in U.S	S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)-		e - Americ		
9	or Ite	3	1 ☐ Never Married 2 ☐ Mar	ried 1 ☐ Ye	es 2 (XIN	lo	-	1 ☐ Yes			, 1 46110 1	moarr, otc./					
8	Per.	l by	3 ☐ Widowed 4 ☑ Divorced	d ff Yes, Year o	or Dates:			1 1 105	20 <u>0</u> 0 NO	Spacity.				Specify	v: Whit	.e	
21215-0036	72 hg	Completed	15. Deceder (Specify only higher	nt's Education	ed)		16a. Dece	dent's Usu	al Occupa	ation during most	t of workir	na	16b. Ki	nd of B	usiness/Ind	lustry	
2	within ene. then "	du	Elementary/Secondary (0-12)		e (1-4or 5	+)	life.	DO NOT u	se retired	)		3					
21	A Para a	Ö		2				Res	pite	Prog	ram 2	Assist	nt	Cou	nty C	overnme	ent
P	e filed at Hygic other vent,	Be (	17. Father's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Middle	, Maiden	Suman	ne)		
<u>a</u>	Mental   Merked o	To	Aloysius Jose	ph Smare	У					Do	ris 1	Marie E	Babbi	ngt	on		
Maryland	should and Men and Men marke		19a. Informant's Name/Relations				19b. Maili	ng Address	(Street a	and Numbe	r or Rura	/ Route Numb	er, City o	r Town,	State, Zip	Code)	
	and 2 salth a n 27 ls		Kathleen Anne	Ferah /	Daugh	nter	12307	She	rwood	d For	est 1	Drive,	Moun	it A	iry,	MD 2177	71
Baltimore,	- 4 5 5		20a. Method of Disposition			20b. Pl	ace of Dispo	sition (Na	me of	e)		ate		cation -	City or To	wn, State	
Ę	Pages nent of int: If it		13℃ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		om State		e of He	-				ember 1			·	26	- 7
量	permit. Pages Department of Important: If Ite eny injury or of		21. Signature of Funeral Service				E24	Nameer	ad Aderes	s of Facilit		006 Funeral	511	ver	_Spri	ng,Mary	71and
Ba	Departi Departi Import eny inj		Acres	50mg	Jens											MD 209	201
			23a. Part1. Enter the disease, o	r complications th	at caused	the death								sp	ring,	Approximate	
			shock, or heart failure. Lis Immediate Cause (Final	t only one cause of	on each lin	ie.										Onset and Dea	
ğ.	Physician /Medical		disease or condition resulting in death)	a			ith Di	stan	t Mei	tasta	ses					2 Yea	ırs
	Examiner			Due	to (or as	a consequ	ence of):										
		-	Sequentially list conditions,	b. Due	to (or as	2 CODSEGU	ence of):										
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	₹	10 (01 23 1	a consequ	orios orj.										
	and and I-trar	xan	that initiated events resulting in death) Last	c	to (or as	a consequ	ence of):										
8760,	ate be executed thysicien and the burial-transit	E			10 (0, 00	2 00110044	31,00										
87	physi s the b	dical		d													
Box 68	leath certific ettending pl	Med	IF FEMALE;	22 H													
30	ath c	an	23b. Was decedent pregnant in the past 12 months?		ve birth	2 Fetal	death 3[	Ectopic p					1		te of delive onth	ry Day Yea	ar
	tha e	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at nknown	time of de	ath 5	Other (s	oecify)								
P.O.	that the da ned by tha e detached t	Physician/M					laine in the second			. in On a l		22a Dida				e cause of deal	ath 2
Ś,	8 50	þ	Part II. Other significant conditions Chronic Obstructure	ctive Lu	ng Di	seas.	e, Res	pira	ause give tory	Fail	ure					ably 4 K Unk	
Records,	w require been si should I	ted					-					10	165 21	_1N0	3   100	abiy 4 gorik	MOMII
Š	law es b	ple										24a. Was		24b.	Were autoprior to cor	psy findings ava notetion of caus	ailabfe se of
Œ	rician: The lav certificate hes rector, page 2	Completed											rmed?		death?	2 □ No	
Vital	ratific ctor,	Be (	25. Was case referred to medica	ıl						26. Place	of Death	(Check only	опе)				
>	ysic lis ce dire	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	☐ Inpatie	nt 2 🗆 E	ER/Outpatier	nt 3 🗆 D0	Othe Othe	9r: 4 🗍 Nu	rsing Hor	ne 5 ⊡xResi	dence	6 □Oth	er (Specify	)	
J of	ig Pt ter th neral		27. Manner of Death	28a. D	ate of Injur Month, Day	y (Year)	28b. Time o	f :	28c. Injury Work			28d. Describe					
ō	ath. r: Af	atic	1X Natural 5 ☐ Pendi 2 ☐ Accident invest	igation	,,	112.7	()	М		Yes 2□	No						
Division	Atte	110	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	_: [ 289, P]	ace of Inju	ry - At ho	me, farm, sti	eet, factor	y, office		2	28f. Location ( City or To	Street an	d Numb	er or Rura	I Route Number	r,
	s afte	Certification:	, and the same see		unding, or	. (Openy	,					Only or 10	WII, State	,			
	hour hour ners y fille		29a. Certifier 1 CCertifyi	ng Physicien: To	the best	of my know	vledge, deat	h occurred	at the tim	ne, date an	d place, a	and due to the	cause(s)	and ma	anner as st	ated.	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only 2 Medical one)	Examiner: On the	e basis of nanner sta	examinat ted.	ion and/or in	vestigation	ı, in my op	oinion, dea	th occurre	ed at the time,	date and	place,	and due to	the cause(s)	
	To the To the Somp	X	29b. Signature and title of certific	er a				29	c. License	number			29d. Dat	e signe	d (Month,	Day, Year)	
	(D		1 por	Meclan	1				D	1765	7.		S	epte	ember	7, 200	16
	10		30. Name and address of persor			eath (Item	23a) (Tyne	Print)	ν.	1703	0						
			Tipapurn Woo			·		•	Aver	nie.	#550	Chevy	Cha	92	MD 3	0815	
	Sta	ate	31. Date filed (Month, Day, Year	) 3:	Registra				11V C1		,, 550 /	Cirevy	Cild	50,	110 2	2013	
	Regist		SEP - 8	3 2006	CO BILE	10	(60)	de									

	1 - State Registrarper FH 9/7/06 2	ACO HEALTH DEPT CM		rtment of Hotelin of Lificate of L			Reg. No 2001	30202
an	1. Decedent's Name (First, Middle, Last, Marilyn M. Hooker					2. Date of De Month Septemi	Day Yea	
al er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De		4c. County of De	
ÇI	1016 Jigger Court			Annapolis	3		Anne Ar	un de 1
	5. Social Security Number 6. Sec	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		ay, Year)	Birthplace (State or Foreign Country) ssachusetts
	Usual Residence of Decedent							
Director	10a. State 10b. County Prince (Maryland Prince Ger	Georges Bowie		cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
ia.	12709 Bridle Plac	е		20715			United St	ates
by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar ☐ Yes 2 X No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Black, W	merican Indian, hite, etc. White
Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most of v	vorking	16b. Kind of Busine	ss/Industry
E	Elementary/Secondary (0-12)	College (1-4or 5+)		Secretar	7		Dept. of	Agriculture
Be	17. Father's Name (First, Middle, Last) George Michael	<u> </u>				,	, Maiden Sumame)	
P :	George Michel  19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Mailin		Edith C		per, City or Town, State	e. Zip Code)
	Kevin Hooker / So	n 194	2709	Bridle P	lace b	owie. Ma	rvland 207	
	20a. Method of Disposition	20b. Plac	e of Dispo	Bridle Place sition (Name of natory or other place	œ, Howie	e, Maryland	20c. Location - City	or Town, State
	1 ☐ Burial 2 XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			Crematory		/2006	Bal timo re	, Maryland
	21. Signature of Funeral Service Licens		22	Name and Addres	s of Facility	John M.	Taylor Fund	eral Home,In is, MD 21401
dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory  Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer  d.	Failunce of):					Interval Between Onset and Death
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
Completed by Ph	Part II. Other significant conditions co	ntributing to death but not resultii	ng in the ur	nderlying cause give	n in Part I.	1 ∑ 24a. Was auto	Yes 2 No 3 Description of the san 24b. Were prior death	e to the cause of death?  Probably 4 Unknown autopsy findings available to completion of cause of ? es 2 No
Be	25. Was case referred to medical examiner?	1 9.1.		1 04		Death (Check only	one)	Sisters
၉	1 ☐ Yes 2 ☐ No			t 3 DOA Othe	4 L Nursing		idence 6 Other (S	pecify) Home
Certification:	27. Manner of Death  1 Accident  2 Accident  3 Suicide  2 Could not be	(Month, Day Year)	Bb. Time of Injury		at ? ′es 2 □ No		how injury occurred	
Certif	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, rarm, str	eet, factory, office			(Street and Number or wn, State)	Hurai Houle Number,
edicai		sician: To the bast of my knowle ner: On the basis of examination and manner stated.						
ž	29b. Signature and title of certifier		, . (	29c. License	number		29d. Date signed (Mo	onth, Day, Year)
	Canto	18-1-1	11/	053306	5		9/6/2006	
	30. Name and address of person who	m leted cause of death (Itom 2)	3a) (Tune	Print)				

		1 - For State Registrar		Sta			I / Depa		t of H	ealth a	and M	lental Hyg	iiene	006	302	203
Physicia /Medic		1. Decedent's Nam Jeffrey	Lynn I	lines								2. Date of Dea Month	Day	Year ZUOL	3. Time of 1	A <sub>M</sub>
Examine		4a. Facility Name (	yland .	Avenue					ersto	Location of WIN  If Under			Was	inty of Death hington		
Funeral Director		5. Social Security I 218-50- Usual Residence of	3585	6. Sex 1 <b>⊠</b> M 2		6 (In yrs. la	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month Day 06/02/1	956	9. Birthpi Coun	ace (State or ry) MD	r Foreign
Maryland I-f ahow	tor	10a. State MD	10b. County Washi				Town or Lo							10	0d. Inside City 1 X Yes	
h with the 23s or 28s	Funeral Director	10e. Street and Nu 945 Mar		Avenue				10f. Zip	Code 21740	)			log. Citizen US	of What Coun	ry?	
Itimore, Maryland 21215-0036  III. Pages 1 and 2 should be filed within 72 hours after death with the Maryland strinent of Health and Mental Hygiene.  The fire of Health and Mental Hygiene and the fire of them 21 a process. It should not yet a marked other than "natural", or than 23 a or 28 a-f ahow nighty or other traumatic event, the Medical Examinat must be notified at the	þ	11. Marital Status 1 X Never Mar 3 ☐ Widowed		rned 1 [	as Decedent med Forces? Yes 2 📉 Yes, Give ear or Dates:			Was Deced If Yes, spec				acify Yes or No- Rican, etc.)		Race - America Black, White, e ecify: Whi		
Maryland 21215-0036 The and a should be filled within 72 hours att Ith and Mental Hygiene. The marked other then "naturel", or traumatic avent, the Medical Exerci-	Completed	(Spe Elementary/Sec 11	cify only highe	1		5+)	16a. Dece (Give life.	dent's Usua kind of woi DO NOT us Labor	rk done d se retired)	ution Tu <i>ring</i> mos	t of work	ing		onstru		
Maryland 2 should be file s and Mental Hy I marked oth	To Be (	17. Father's Name James J										Ann Bart		name)		
Mary and 2 sho talth and 8		19a. Informant's Mary An										Al Route Number Hagersto				
Baltimore, Mispermit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any njury or other tra			sposition Cremation 5 Other (S		al from State	20b. Pla	ice of Dispo metery, crei ar La	sition (Nan natory or o wn Mei	ne of ther place m. Pa	ark 0		)/2006		on - City or To		
Balti permit. Departm Importe any nju		21. Signature of F	uneral Service	Licensee		2						rald N. eet, Hag				
Physician /Medical Examiner per partial-transit per partial-transi	cal Examiner	23a. Part1. Enter shock, or he Immediate Cause disease or conditions of the condition of the cause (Disease of that inditated event resulting in death)	(Final on onditions, on onditions, or injury is	b	Alcohul Due to (or as Angrey	a conseque	ence of):	er the mod	e of dying	g, such as	cardiac	or respiratory are	est,		Approximate Interval Betwonset and Demostration Demostrat	veen
ste be	Completed by Physician/Medic	IF FEMALE: 23b. Was deceded in the past 1/ 1 ☐ Yes 2 9 ☐ Unknow	2 months? □No	1( 4(	yes, outcome Live birth Pregnant at Unknown	2 Fetal	death 3[	Ectopic pr					23d.	Date of delive Month		ear
cords, P	ed by Pt	Part II. Other sign		ons contributi	ng to death b	ut not resul	ting in the u	nderlying c	ause give	n in Part I.		23e. Did to		ontribute to th	e cause of de	
	Complet											24a. Was a autop: perfor	SV	death?	sy findings a apletion of ca 2 No	
of Vita Physician: r this certific	To Be	25. Was case reference examiner?		Hospita	al: 1 🗆 Inpatie	ent 2 🗆 E	R/Outpatier	nt 3 DC	A Othe			me 5X Resid	4	Other (Specify	)	
Vision of Attending Phore of death.	Medical Certification:	27. Manner of Dea 1 XNatural 2 ☐ Accident 3 ☐ Suicide	5 Pendi	igation	a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	М		at ? (es 2)		28d. Describe h				
Divisic To the Hospital or Attending Within 24 hours after death To the Funerel Director: completely filled in by the	Certif	4  Homicide	deterr	nined 286		c. (Specify)						City or Tow	n, State)	imber or Rural		oer,
the Hosp hin 24 ho the Fund mpletely f	Medica	29a. Certifier (Check only one)  29b. Signature and	2 ∐ Medica	Examiner: C	: To the best on the basis o and manner st	f examination	ledge, deat on and/or in	vestigation	at the tim , in my op c. License	inion, dea	d place, th occurr	and due to the cled at the time, d	ate and plac	manner as sta ce, and due to gned (Month, L	the cause(s)	
Will T on o		Bu	hul. 7	full	-hmo			D	0062				,	12006	y, rodij	
Stal Registra		30. Name and add Burb hvu 31. Date filed (Mo	A. Hred	Her, Mo					te 102	. Hug	ierstru	vn, Mo	21740			

			A FOI	partment of Health and Mertificate of Death		ene 1 No 2 N N 6 3 N 2 N 4
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Charles Leonard HUTZELL Sr.		Month / S	Day 2006 12:50 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Washington County Hospital	Hagerstown		Washington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
	Director		220-34-10/8 69		June 10	1937 Maryland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryi	ŏ	Manusland Hashington Hos	o wa torra		1 ☐ Yes 2X No
	the 28e	Director	Maryland Washington Hag  10e. Street and Number	erstown 10f. Zip Code	100	. Citizen of What Country?
	3a oi		11800 Partridge Trail	21742		USA
	death	Funeral		J. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
ဖွ	after or its		1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married If Yes, Give	1 ☐ Yes 2 No Specify:	rican, etc.)	Black, White, etc.
93	72 hours after death with the Maryland neturel; or iteme 23a or 28e-f ehow dical Examiner must be nutified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	TO THE ZAD ING Specify.		Specify: White
21215-0036	d within 72 hours after death with the Marylar piene. r than "neturel", or iteme 23a or 28e-f ehow the Modical Examinat must be nutified at	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation we kind of work done during most of work	ing 16	b. Kind of Business/Industry
12	within ene. than "	m m	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) ter Reader		City Corromment
7	Hygie Hygie Sther Int.	မ င	10 0 Me		e (First, Middle, Ma	City Government
Maryland	d be	8	Russell John Hutzell			hittington
<u></u>	shoul nd Me mark mati	Ç		iling Address (Street and Number or Run		
<u>S</u>	nd 2 g			the state of the s		own, Maryland 21740
ē,	es 1 and 2 should be filed v of Health and Mental Hygie if Item 27 is marked other i ir other traumatic event, it		20a Method of Disposition 20b. Place of Dis			Oc. Location - City or Town, State
9	Peges nent of I int: If its iry or o		1 □ Burial 2 KgCremation 3 □ Hemoval from State	wn Crematory 4/12	/06 F	Hagerstown, Maryland
Baltimore,	글본란를 .		the state of the s			neral Home
Õ	Depa impo any i		Calute & Kandi	415 E. Wilson Blvd	, Hagers	town, Md. 21740
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between
	Physician			STAIC LUNG G	NCER	
	/Medical		resulting in death)  Due to (or as a consequence of):		2	
	Examiner		Sequentially list conditions. b. Obsty	STAIR LUNG C	disea!	se years.
	sit sed	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J		
	and and ii-tran	Examiner	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):			
8760,	cate be executed physicien and the burial-transit	a! E				ľ
687	death certificate be executed e ettending physicien and d for use as the burial-transit	Physician/Medical	Q	-		
Вох	eath certific ettending p for use as	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
		sicia		☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	at the de by the e	hys	9 LI ORKROWN			
	requires that the een signed by th hould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
ord	w requir been s should	ted	meumoma		Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	aw asb	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>=</u>		Co			performe 1 ☐ Yes 2	d? death? No 1 □ Yes 2 □ No
Ę.	Physician: 1 this certifice ral director, p	Be	25. Was case referred to medical examiner?	Othor	(Check only one)	
o		2	1 ☐ Yes 2 No Hospital: Inpatient 2 ☐ ER/Outpat 27. Magner of Death 28a. Date of Injury 28b. Time		me 5 Residence 28d. Describe how	ce 6 Other (Specify)
on	ding Phy th. : After thii funeral o	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation		200. 2000120 1104	anjury occurred
/isi	or Attending ter death. frector: After n by the fune	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,			et and Number or Rural Route Number,
ă	al or A s after of Dire	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)
	To the Hospital or Attent within 24 hours after deall To the Funerel Director: completely filled in by the	cai	29a. Certifier (Check only   Medical Examinar: On the basis of examination and/or	ath occurred at the time, date and place,	and due to the caus	se(s) and manner as stated.
	the H the F the F	ledicai	and manner stated.			
	within 2 To the	Σ	29b. Signature and title of certifier	29c. License number	400	I. Date signed (Month, Day, Year)
يع ا	177		7	194996	3	premser 8, 2006
,	4		30. Name and address of person who completed cause of death (Item 23a) (Typ		nsRel	Bonsboro MD 471;
	Sta Registr		31. Date filed (Month, Day, Year)  SFP 1 1 2006  32. Registrar's Signature	seele		
			SEP 11 2000 Been 10. 1			

7.	
State of Maryland / Department of Heal	th and Mental Hygiene 2006
State of Maryland, Dopartment of the	11 and 11 on tall 11 y 3 or 11 2 0 0 0

30205

	1-	For State Registrar					rtificate				Reg. No	).		
Physician /Medical		Decedent's Name ( Katheri	First, Middle, Last) ne Wrigl	nt Hug	uenin					2. Date of D Month Septer	Da	9, 2006		
Examiner			ot institution, give si lemorial H		ər)		4b. City, To		Location of Death		40	. County of Dea lashingt	ath	
uneral irector	5. 5	Social Security Nun 21 <b>7–</b> 28–12	nber 6. Sex		Age (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of E (Month, I 11/06)	Birth Day, Year, 1925	9. Bi	rthplace (State or For country) MD	
show	108		ecedent Ob. County Washingto	nn.		, Town or Lo							10d. Inside City Lir 1	
be notified	106	e. Street and Numb	er		Tia	501000	10f. Zip C 217		·			tizen of What C		
Important: if Item 27 is marked other then "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinat must be notified at ones.  To Be Completed by Funeral Director	_	. Marital Status  1 Never Married  3 Widowed 4	1 2 Married	2. Was Decede Armed Force 1  Yes 2  If Yes, Give Year or Date	s? XNo		Was Decede If Yes, specif		spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or to Rican, etc.)	No-	14. Race - Arr Black, Wh Specify:		
nerthen "natura t, tre Medical E Completed b		1 (Specify	5. Decedent's Educ only highest grade	ation completed)		(Give	dent's Usual kind of work DO NOT use	done di	tion uring most of wor	king	16b. F	(ind of Busines	s/Industry	
ent, the sent ent.		Elementary/Second 12 . Father's Name (Fi		College (1-4	or 5+)	Admi	nistra		e Assist				vernment	
marked of		Jesse Ear	1 Kohler	e, Print)		19b. Mailii	ng Address (	Street a	Anne Vi				Zip Code)	
em 27 is. ther trau			Huguenir			1892	7 Mano	hes	ter Driv	e, Hago	ersto	own, MD	21742	
rtant: If ite njury or o		1 □ Burial 2 🛭 4 □ Denation 5	Cremation 3 Re Other (Specify)	7	ate C	<sub>emetery, cre</sub> ithsbu	natory or oth rg Cre	er place mate	ory Sept	10,200	6 Smi	thsburg		
e ng		Press		WH	<u></u>	3	05 N.	Pot	omac Str	eet, H	agers		1D 21740	
sician edical	di	shock heart shock heart nmediate Cause (Fi sease or condition sulting in death)	disease, or complic failure. List only on inal	a cause or eac	h line. NY LO CO		Lym.		7 rut	Infector	rarrest,		Approximate Interval Between Onset and Death	
i burial-transit	Se if a ca Ca tha	equentially list cond any, leading to imm ause. Enter Underly ause (Disease or in at initiated events sulting in death) La	ditions, bediate ring jury c	Due to (or	as a consequence as a linear	we f	teant.	80	due				2-3 mm	
d by the attending physicis letached for use as the burner	IF 23	FEMALE:  3b. Was decedent p in the past 12 m 1  Yes 2  1	onths?		n 2 ∏ Feta ntattime of d	Ideath 3	□Ectopic pre □ Other (spe					23d. Date of d Month	elivery Day Year	
be be		art II. Other signific	ant conditions con	tributing to deat	th but not res	ulting in the u	inderlying ca	ıse give	n in Part I.					
np np	-									ре	as an topsy rformed?	prior to	completion of cause	
r this certificete fral director, page	25	5. Was case referre examiner? 1 Tyes 2 KN	l u	ospital: 1 🗆 Inp	ationt 2	ER/Outpatie	nt 3 DOA	Othe	26. Place of Dea	ath (Check onl	y one)		nonifu)	
\$ 5 D	27	7. Manner of Death 1 Natural 2 Accident	5 Pending investigation	28a. Date of (Month,		28b. Time of Injury		c. Injury Work		28d. Describ			вспу)	
Ne Funeral Director: A bletely filled in by the fr edical Certificati	27. Manner of Death  1										(Street a Town, Stat	Onset and Death  2-3 Month  2-4b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  In occurred  and Number or Rural Route Number, e)  3) and manner as stated.  d place, and due to the cause(s)		
Funer ely fill icai					is of examina									
To the complet		9b. Signature and ti	ul A	dw/m	ND.		29c.	A	P6561		1 -		nth, Day, Year) 9, 2006	
4			ss of person who co	mpleted cause	of death (Iten			ro	MD 2171	3 /301				
State Registrar	31	1. Date filed (Month	la Qadir , Day, Year) SEP 112	32. Re	istrar's Signa	iture	best	,			.02	~		

DHMH 17 Rev 1/2001

27H-6

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygien 2006 30206 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician September 6 2006 10:20A M Smith Houck Kenneth /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner College View Center Frederick Frederick 8. Date of Birth (Month, Day, Year) Apr. 23, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1**X** M 2□ F Maryland 1920 86 220-09-8298 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Count r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 XYas 2 No Director Frederick Woodsboro Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21798 U.S.A. 104 N. Second St. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. a filed within 72 hours after d il Hygiene. other than "natural", or itam 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 processor & cheesemaker other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any liury or other traumatic event 2008. Be Ira G. Houck Beulah Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) G. Lorraine Houck/ wife 104 N. Second St. Woodsboro, MD 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/2006 Woodsboro, MD Mt. Hope Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home attarine ) 404 S. Main St. Woodsboro, MD 21798 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an s certificate has the 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifier 29c. License number WSL MB 9.7-2006 D006041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Frederick DV 65-C Thomas Hemein Tourson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2006 30207 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** September 8, 2006 9:15George William Higgs, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges 8311 Cedarville Road Brandywine If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2□F Months 79 Mar. 4, 1927 Director 579-26**-**0509 Washington DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County il Hygiene. . other than "neturel", or items 23a or 28a-f show vent, the Medical Exeminer must be notified at 1 Yes X No Completed by Funeral Director Maryland | Prince Georges Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8311 Cedarville Road 20613 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates: WWII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sheet Metal Fabricator Building Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil tment of Health and Mental Heart: If Item 27 is marked ott jury or other treumatic even Be George Richard Higgs unavailable ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8311 Cedarville Road, Brandywine, MD 20613 Mabel Higgs - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Depertment of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans' Cem 9-13-06 Cheltenham, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility M01391 3035 01d Washington Rd. Huntt Funeral Home POB 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) months **Physician** /Medical **Examiner** S\_quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Physicism: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Consistive Heart Failure 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No 1 Yes 2 □ No Division of Vital : After this certification of the state of t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 19 29d. Date signed (Nonth, Day, Year) 29b. Signat who completed cause of death (Item 23a) (Type, Print) 1051 Dr. Charlene A. Letchford, 404 E. Charles St., LaPlata, MD 20646 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 1 1 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician la s 2006 1802 M MARSHA JAVINS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** chever George's Hospita Frince 6 coyes If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) rauca Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 XF Director Wash., DC 579-58-2393 63 Mar. Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Maryland Prince George's Capitol Heights Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743-2960 1006 Quietview Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e fited within 72 hours after d at Hygiene. other than "natural", or Item 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 27 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. **Black** δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Homemaker s 1 and 2 should be filed if Health and Mental Hygie Item 27 is marked other other traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lloyd Dickerson Mary Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 a Department of Health ar Important: If item 27 is any in ury or other trau Maurice F. Javins/Husband 1006 Quietview Drive, Captitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 9/12/2006 Cheltenham, MD 22. Name and Address of Facility 21. Signature of Pineral Service Licensee Stewart Funeral Home 4001 Berning Rd., NE Wash., DC 20019 Part1. Anter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or coodition resulting in death) Atheroscherte Cardiovascular Heart Diseas **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 MUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2. No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2-ER/Outpatient 3 DOA 2 After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral I 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospita 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 2006 Registrar

			1 - For State Registrar		State of	Marylan		artmen rtificat				lental Hyg	iene g. No.20	06	3020	9
	Physici		1. Decedent's Name (First, Mide Betty		Darlin	e	.IoI	nnson				2. Date of Deat Month Septemb	Day	Year	3. Time of Death 7:45 a	м
	/Medic Examir		4a. Facility Name (If not institution						Town, or	Location of	of Death	Septem		y of Death	_ / • 43 a	
			409 5th Stree	t				Anna	apo1:	is			Anne	e Arui	ndel_	
	Funeral Director		5. Social Security Number 219–28–8595	6. Sex	м 2[ <b>Х</b> F	7. Age (In yrs. 72	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, June 2	Year)		place (State or Forei ntry) 71and	ign
	land ow		Usual Residence of Decedent  10a. State 10b. Count	у		10c. Cit	y, Town or Lo	ocation						1	0d. Inside City Limi	its
	Mary B-f sh	tor	MD Anne	Aru	nde1	An	napoli	İs							1 □ Yes 🎎 🛣	10
	or 28	Jire	10e. Street and Number					10f. Zip	Code			1	0g. Citizen of	What Cour	ntry?	
	ath w	rai	801 Latchmere						2140				USA			
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 ie markad othar then "neturel", or itams 23a or 28e-f show any injury or othar treumetic evant, the Madical Examinations to Indianal at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4XX0ivorce	rried	12. Was Dece Armed For 1 ☐ Yes tf Yes, Giv Year or Da	dent Ever in U. rces? 2 XX No e ates:		Was Deced If Yes, sped 1 ☐ Yes				ecify Yes or No- Rican, etc.)		ice - Americ ack, White, ify: Wh		
21215-0036	nin 72 hou n "neture Mevical E	Completed by	15. Decede (Specify only high Elementary/Secondary (0-12)	est grade	cation		16a. Dece (Give life.	dent's Usua kind of wo DO NOT u	rk done d	turina mos	t of worki	ng	16b. Kind of E	Business/In	dustry	
212	d with greene gar the	Com	12		College (1	-401 34)	Homen	naker					Own	Home		
Maryland	be file ad oth evant	Be	17. Father's Name (First, Middle Flaviano V. A		io							(First, Middle, I irginia		me)		
ıryk	should nd Mer marku metic	ပ္	19a. Informant's Name/Relation				19b. Maili	ng Address	(Street a			I Route Number		, State, Zip	Code)	
	and 2 alth ar		Kimberly Sue	John	son (D	aughter	807	Shore	e Dr	ive,	Edge	water, N	D 2103	37		
ore	of He of He of item		20a. Method of Disposition			20b. P	lace of Dispo	mataniae a	ther also	e)			20c. Location	•		
Baltimore,	it. Pag rtment rtant: njury c		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 21. Signature of Funeral Service			ment Hi		st Cer			9-9-	2006	Annapo	lis,	MD	
Ba	Depa Impo any in		· Sati	W	//(			Harde 12 R:	esty idge	Fune: Ly Av	ra1 l enue	Home, P. Annapo		D 214		
8760,	/Medical Examiner bhysician and the burial-transit the burial-transit	dicai Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	t t only or	Due to (	ach line.	CINO we uence of):		^	Lun	5				Approximate Interval Batween Onset and Death	n\$
O. Box 6	The law requires that the death certificale be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 ☐ Yes 24 No 9 ☐ Unknown	2	1∏Live b	come of pregna irth 2 □ Feta ant at time of do own	Ideath 3[	⊒Ectopic pi ] Other (sp			•			ate of delive	ery Day Year	
<u>α</u>	uires that n signed b ild be deta		Part II. Other significant condi	tions cor	ntributing to de	eath but not res	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did tob			ne cause of death? pably 4 DUnknov	wn
Recol	The law requir ate has been si page 2 should	Completed by										24a. Was a autops perform	n 24b. y ned?	Were auto prior to co death? 1 \( \text{Yes} \)	psy findings availab mpletion of cause o 2 \( \text{No} \)	ole if
/ita	cian: ertific actor,	Be (	25. Was case referred to medic examiner?						100		of Death	(Check only on	(e)			
Division of Vital Records,	To the Hospital or Attending Phyeician: The law within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	Pospital: 1   Inpatient 2   ER/Outpat							OA Other	4 🗀 Nu	2	me 5 ☐ Reside 28d. Describe ho	-	her (Specif rred	vesance	15
Divis	To the Hospital or Attending F within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide detei	1 not be mined	28e. Place buildir	of Injury - At hong, etc. (Specify	ome, farm, sti	eet, factory	, office			28f. Location (St City or Town		ber or Rura	il Route Number,	
	To the Hospital or within 24 hours after To the Funaral Director completely filled in the filled in	Medical (				asis of examina						and due to the ca ed at the time, d				
	within To the compl	Me	29b. Signature and title of certif	ier	- 4				. License		2		9d. Date sign			
			flum	e l	ven	4			25	28:	50	S	epten	ber	6,2006	
_	5		30. Name and address of person	seri	mpleted caus	e of death (tter	1 23a) (Type,	Print)	d H	300	An	napoli	SIMA	214	6,2006	
	Sta Registi		31. Date filed (Month, Day, Yea	<b>7</b> 200		egistrar's Signa	ture	all of		(		,			·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200630210 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year ames Service 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death SNOW HILL NUTSING 4 Kehab, Cent Norcester der 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 865 Months Days Hours Min. 1□M 2ÎXF 10-Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No 10f. Zip Code 10g. Citizen of What Country? 86 . Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Black 3 ₩Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ghores anhertron 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of semetery, crematory or other place) tockton 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9-06 Cen Onc 2. Name and Address of Facility BCNNIC 21. Signature of Funera S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or barr failure. List only one cause on each line. Approximate Interval Between Onset and Death STAGE Immediate Cause (Final disease or condition resulting in death) EHD RENAL Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2L-No 2DANO 26. Place of Death Check only one Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examine certificate be executed use as the burial-transit ed by the attending physicien and detached for use as the burial-trai Box 68760, Physician/Medical P.O. cate has been signed by page 2 should be detacl Records, ۾ Completed this certificate of Vital Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be Certification: To Division

**Physician** 

/Medical

Examiner

10a, State

Director

by Funeral

Completed

Be

**Funeral** 

Director

ith and Mental Hygiane. 27 is marked other then "natural", or items 23a or 28a-1 ehow treumatic event, the Madical Examinar must be notified at

other treus

permit. Pages 1
Department of H
importent: If ite
any injury or ot

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00062172 9/5/2006

1604 MARKET ST. POCOMOKE CITY MD SATYAL, MD 31. Date filed (Month, Day, Year)

State Registrar

cal

SEP 1 1 2006



BA 1

Hospitel or

William James Knight

Please Type or Print in Blac	k Indelible Ink		
State of Maryland / Department of Hea	alth and Mental Hygiene		
Certificate of Dea	ath Reg. No	200	)
rst, Middle,Last)	2. Date of Death		3

mam James	Killy	1- For State Certifica	ent of Health and Menta ate of Death		g No 2006 30
Physici		Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3 Time of Death
ledical Exam	iner	william James Killynt	Lab City Taylor and anation of	Month September	
		Facility Name (if not institution, give street and number)     Appleton Lane	4b. City, Town, or Location of Bowie	Death	4c. County of Death Prince George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 579-06-2901 1 M 2 F 37	Months Days Hours  Yrs.	Min.	/1968 Seinthplace (State or Country)
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of the County 10c. City, Cit	or Location		10d. Inside City Li
*	'n	MD PG Bow	rie		1 Yes 2
Maryla r 28a-f	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
vith the s 23a o e notifi		2511 Appleton Lane  11. Marital Status 12. Was Decedent Ever in U.S.	20716  13. Was Decedent of Hispanic Origin	n? ( Specify Yes or No-	USA  14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens I matural", or items 23a or 28a-f shu Important: If item 77 is marked other than "natural", or items 23a or 28a-f shu injury or other traunuatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, P	Puerto Ricán, etc.)	White, etc.
irs after ural". miner	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. I	Yes 2 X No specify:  Decedent's Usual Occupation (Give kir	nd of work done	Specify: Black  16b. Kind of Business/Industry
21215-0036 uld be filed within 72 hours after Mental Hygiens marked other than "natural": event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	luring most of working life. DO NOT us		, and a decimal of the second
003( within grene ner tha	dmo	12th	Auto Saleman	Name (First Middle N	Private
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be C	17. Father's Name (First, Middle, Last)  William J. Knight, Sr.		Name (First, Middle, Manne (First, Middle, Manne Le	,
21; hould b nd Men is mar	To	19a Informant's Name/Relationship (Type, Print )	. Mailing Address (Street and Number	er or Rural Route Numb	per, City or Town, State, Zip Code)
, MD and 2 sho ealth and em 27 is ranmati			511 Appleton Lane f Disposition (Name of cemetery,		D 20716  20c. Location - City or Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 XXBurial 2 Cremation 3 Removal from State cremator	ory or other place)		Bladenburg, Maryla
altin mit. Pa partmen portan ury or		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		
		Gendantreenan	5801 Cleveland	Avenue; Ri	verdale, MD 20737
Physician /Medical		23a. Par D Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.			st, shock, or heart Approximate Inte Between Onset Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot wounds (2) of torso  Due to (or as a consequence of):	and blunt force nead injuries	5	Dodan
	<u>.</u>	Sequentially list conditions,   b.			
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated			
uted d ansit	ω̈.	events resulting in death) Last Due to (or as a consequence of):  d.			
'60, sate be executed oblysician and ne burial - transit	Medical	UNPENDED AMENDED			
Box 68760, e death certificate be ex the attending physician red for use as the burial -	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic p	nregnancy	23d. Date of delivery  Month Day Year
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	/sician/l	past 12 months? 2 4 Pregnant at time of death 5		regilalicy	Month Day 1ear
O. B. B. Chart the dea	Phys	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part	I 23e Did tob	pacco use contribute to the cause of death?
P.O.	<u>\$</u>		,		2 No 3 Probably 4 Unkno
ords, w requir s been s should	Completed			24a. Was a	
Recc The lav	omb			perform 1 ✓ Yes 2	ned? death?
ital Rec ician: The l certificate l	Be	25. Was case referred to medical examiner?	26.Place of Death (C		
1 of Vi ling Physi After this funeral did	유	1 V Yes 2 No Impatient 2 Environment 27 Manner of Double 1 290 Date of laying 290 Date of	itpatient 3 DOA Other 4 N ime of Injury 28c. Injury at Work?		Residence 6 Other: Scene ow injury occurred
ion ( tending eath or: At the fun	ation	1 Natural 5 Pending Sep 6, 2006 2228	hrs 1 Yes 2 V N	Subject shot	and assaulted
Division of Vital Records, tal or Attending Physician: The law requires after death all Director: After this certificate has been seled in by the funeral director, page 2 should I	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.	28f. Location (St or Town, Sta	treet and Number or Rural Route Number, ate)
Di To the Hospital within 24 hours a Fo the Funeral I		29d. Certifier 1 Continue Physicians To the heat of any brough day does	the accurred of the time, date and along		on Lane, Bowie, MD
To the Hospital within 24 hours Fo the Funeral completely fille	Medical	(Check only one) 2 Medical Examiner: On the bast of my knowledge, dea			
- 5 2 5 8	Me	29b Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
(5)		Fatultonica-follow-	O.C.M.E.		September 7, 2006
CR		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Exam	iner 111 Penn Street, Balt	imore, MD 21201	
	tate	31 Date filed (Month, Day Year) 2. Registrar's Signature	•	,	
Regis	trar	SEP 1 2 2006	all .		
DHMH 17 Rev 1/3 OCME 2006	2001	- OR	IGINAL		

			For	State of N	/laryland	/ Depa	artment	of He	alth a	ind Me	ental Hy	giene	200	16	302	12
			1 - State Registrar			Cei	tificate	of D	eath			Reg. No.	200			
	Physici	an	1. Decedent's Name (First, Midd								2. Date of De Month	Day			3. Time of Dea	
	/Medic		KYE HWA  4a. Facility Name (If not institution	KIM	or)		4b. City, To	own. or L	ocation of		SEPT.		2006 County of D	eath	8:30A	7
	Examir	er	RANDOLPH HI			ar .	SIL						ONTGO		v	
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. la		If Under 1	Year	If Under 2		B. Date of Birt (Month, Da				e (State or Fo	reign
	Director		216 96 2568	1□M 2XF	95	Yrs.	Months	Jays	110013		EPT 1		1910		OREA	
	iand wo		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City,	Town or Lo	cation							10d.	Inside City Li	mits
	Many First	to	MD MON	NTGOMERY	SI	LVER	SPR	ING							1 X es 2	] No
	or 28a	irec	10e. Street and Number				10f. Zip C	ode				10g. Citiz	en of What	Country	?	
	within 72 hours after death with the Maryland ane. then "neturel", or Iteme 23a or 28a-1 show is Medical Exist, ther treat be notified at	Funeral Director	4011 RANDOLI	PH RD			20	0902	2			US.	A			
	er dez	une	11. Marital Status	12. Was Deceder Armed Forces	s?	. 13. \	Vas Deceder f Yes, specify	nt of Hisp Cuban,	anic Orig Mexican,	jin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		4. Race - A Black, W	hite, etc.		
36	urs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	X X s:		∏Yes 2	No	Specify:				Specify: I	ASIA	N	
21215-0036	2 hou	ted	15. Decede	ent's Education		16a. Deced	lent's Usual (	Occupati	on			16b. Kir	nd of Busine	ss/Indus	try	-
2	ithin 7	Completed	Elementary/Secondary (0-12)	est grade completed)  College (1-40)	r 5+)	life. I	kind of work OO NOT use	retired)	nng most	or working	,					
	filed w Hygier other th		12 17. Father's Name (First, Middle	/ (get)		HOU	JSEWII		9. Mathar	r'a Nama /	First, Middle,		PRIVA	AT.E		
Maryland	ed ta b	) Be	CHI SU YOU					1	YI	BA		YAN	Sumame)			
37	should nd Mer marke imaric	Zo.	19a. Informant's Name/Relation	iship (Type, Print)		19b. Mailin	g Address (S	Street and	d Number	r or Rural i	Route Numbe	r, City or	Town, Stat	e, <i>Zip C</i> o	de)	
	s 1 and 2 should f Health and Men item 27 le marke other traumatic		AE SOOK LI	EE /DAUGHT:	ER	139	)11 C	ONGI	RESS	DR	ROCKV	ILL	E MD	208	53	
Baltimore,	Pages 1 au nent of Hea int: If item iry or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	a 3 □Removal from Stat	te cen	netery, cren	sition (Name natory or othe	er place)	_	Da			ation - City		State	
Ē	t. Pag ntmen rtant: njury	1	'4 □Donation 5 □Other	Specify)	NOR	BECK	MEMO		1	9/12			EY MI			
Ba	permit. Pages Department of I Important: If ite any injury or of once.		21. Signatu Fun a Grid	e Licensee			Name and				RLES E JPPER				L SER	
	_		23a. Part1. Enter the disease, of	or complications that cause	ed the death.								прои	Ap	proximate	
	Physician <sup>*</sup>		snock, or near failure. Lis Immediate Cause (Final disease or condition	st only one cause on each			anc ni	DATON							erval Betweer iset and Death	h
	/Medical		resulting in death)		as a conseque	nce of):			NT.TW						YEAR	
L	Examiner		Sequentially list conditions,	PNEUM			ATERAI							ON	E MON	TH
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	LOST	s a conseque SWALL(	,	REF	LEX	WIT	н РО	SSIBI	E -				
<u>,</u>	te be executed ysicien and ne burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a conseque	ence of):	BRAIN	STI	EM S	тв∩к	TE:			ON	E MON	тн
760,	ate be executed hysicien and the burial-transit	cal		d			7143411									
89 >	The law requires that the death certifica ate has been signed by the attending phagge 2 should be detached for use as it	Med	IF FEMALE:													
Вох	death certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal d	leath 3	Ectopic preg					2	3d. Date of Month	delivery Da	y Year	
o.	by the a	Physiclan/M	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown	at time of dea	ith 5L,	Other (spec	ту)								
Δ.	s that	ьу Рһ	Part II. Other significant condit	ions contributing to death	but not result	ing in the ur	derlying cau	se given	in Part I.		23e. Did to	bacco us	e contribute	e to the c	ause of death	?
Records,	w requires that been signed b should be deta						_				1 🗆 Y	es 2	¥No 3□	Probably	/ 4 □Unkno	own
900	law re as bec 2 sho	Completed									24a. Was autop		24b. Were	autopsy	findings availa	able
	sicien: The law s certificate has t lirector, page 2 s	Corr									perfor	med? 2.23 No	death 1 🔲 Y	1?	] No	
Division of Vital	icien: certific ector.	Be	25. Was case referred to medic examiner?	al Hospital:				_			Check only o					
0	this of	.: To	1 Yes 2 No	1 ☐ Inpai		R/Outpatien 8b. Time of	1 3 □ DOA	. Injury a	4) Wiur		e 5 Resid			pecify)		
on	nding P uth. r: After I e funera	atlor	1 Natural 5 Pend 2 Accident inves		Jay Year)	Injury	М	Work?	s 2 □ N							
<u>N</u>	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	minod   286. Place of II	njury - At hom etc. (Specify)	e, farm, str	et, factory, o	office	-	28	f. Location (S City or Tow		Number or	Rural Ro	oute Number,	
	Hospital or Attend 24 hours after death Funerel Director: tely filled in by the										,					
	Hospital 24 hours Funerel itely filled	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the best	of examinatio	edge, death n and/or inv	occurred at restigation, in	the time, my opin	date and ion, death	l place, an h occurred	d due to the o	ause(s) a late and l	and manner place, and c	as stated due to the	d. cause(s)	
	To the Hospital within 24 hours a To the Funerel I completely filled	Mec	29b. Signature and title of certifi	and manner s	314160.		29c. L	icense n	umber			29d. Date	signed (Mo	onth, Day	, Year)	
	- 5 - 0		1	Gun		$\supset$	DO	0023	1033			SEP	г 8,	200	6	
9			30. Name and address of person	n who completed cause of	death (Item 2	23a) (Type,	Print)									
	0		DR BYOUNG I	EE MD., 1	3000	GEOR	IA A	VE	SIL	VER	SPRIN	G M	D 20	906		
	Sta Registr	-	SEP 1 2	2006 2006	strar's Signatur	To Show	W									
			ULI I ~		-	-										

			. For	icasc	State	of Mary	and / De	partmen	t of He	ealth a	and M	ental Hy	/giene	Coo	. ~	00016
			1 - State Registrar			<u>-</u>	C	ertificat	e of D	eath	-			201	16	30213
	Physici	an	Decedent's Name (First,									2. Date of D Month	Day		er /	3. Time of Death
·	/Medic	cal	Elsie Jea  4a. Fecility Name (If not ins		~	ımber)		4h City	Town, or L	ocation o	of Death	septem		4 20 County of E	-	6:30H.M.
	Examir	ier	Baltimore				al Ctr.		Glen					Anne A		iel
	Funeral		5. Social Security Number	6. S			yrs. last birtho	ay) If Under Months		Il Under :		8. Date of B (Month, D				ce (State or Foreign
	Director		236-42-9533 Usual Residence of Deced			7	8 Yrs					Sep. 8				WV
	Mou.		10a. State 10b. 0	ounty		100	. City, Town o	Location							10d	I. Inside City Limits
Ž,	Ba-f s	Director	MD A	nne A	rundel				Sev	<i>y</i> erna	Par	k				1 ☐ Yes 2X No
backack of the back	Iteme 23a or 28a-f show	Dire	10e. Street and Number	0				10f. Zip		1.6			10g. Citi	zen of What		1?
400	ne 23	Funeral	5 St. Andre	ws Ga.	12. Was De	cedent Ever	in U.S.	3. Was Dece	2114		gin? (Spe	cify Yes or N	0-	14. Race - A	JSA merican	Indian,
- 6	or Ite		1 Never Married 2	] Married	Armed F 1 ☐ Yes If Yes, G	2 No		<ol> <li>Was Deceded of Yes, special Yes</li> </ol>			ĭ, Puerto F	Rican, etc.)		Bleck, V	Vhite, etc	<b>3</b> .
-0036	"natural". edical Exa	d by	3 ∑Widowed 4 □ Div		Year or	Dates:								Specify:		ite
21215-0036	Paller	Completed	(Specify only		de completed		16a. De	ecedent's Usua ive kind of wo e. DO NOT us	al Occupati rk done du se retired)	ion ring most	t of workin	ng	16b. Ki	nd of Busine	ess/Indus	stry
212		Ho:	Elementary/Secondary (	)-12)	College	(1-4or 5+)			emake					Home	•	
בום בו	tal Hygi d other	BeC	17. Father's Name (First, M						1	8. Mothe	r's Name	(First, Middle	e, Maiden	Sumame)		
Maryland	2 g 2 0	၉	Leonard Bau						10		-	M. Mil				51.
E S	Heelth and M Item 27 is man		19a. Informant's Name/Re Dan E. Knig					ailing Address 009 Cra							e, <i>Zip Ci</i> 009	ode)
ē, 5	Item other		20a. Method of Disposition			20	b. Place of Di cemetery,				D	ate		cation - City		ı, State
Baltimore,	ment of tant: If It jury or o		1 🔀 Burial 2 □ Crem 4 □ Donation 5 □ Ot			State	MD Vet			1	Sep.	. 8 <b>,</b> 2006	Cr	ownsvi	ille	, MD
Salt	Departmentimportant:		21. Signature of Puneral S	ervice bicen	See 1			22. Name an Barran	d Address	of Facility	y P.	A. Sev	erna	Park	Fune	eral Home
	70740		20mes	6	Ya	DA		490 60	A - 1/T	CCIII	e nw	y, sev	erna	Park,	רוואו	21146 oproximate
	hinia.		23at Part1. Enter the disea shock, or heart failure Immediate Cause (Final	List only	one cause on	each line.	(C)	ontor the mod	o or dying.	30011 43	cardiac or	i i ospii atory	arrest,		In	nterval Between Inset and Death
	hysician /Medical		disease of condition esulting in death)		a. Due to	(or as a cor	sequence of):	your								
Ε	xaminer		Sequentially list conditions		b											
7	ısit	nine	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	' ₹	Due to	(or as a cor	sequence of):									
60,	ysicien and	Examiner	that initiated events resulting in death) Last		C. Due to	(or as a cor	sequence of):									
- 0	ysicie	ical			d											
89 XC	by the attending phy tached for use as th	by Physician/Med	IF FEMALE:		22- 11											
. Box	attenc for us	clan	23b. Was decedent pregna in the past 12 months	an it		birth 2 1 Inant at time	Fetal death	3 □Ectopic pr 5 □ Other (sp					2	23d. Date of Month	delivery Da	ay Year
j j	by the	hysi	1 □ Yes 2 No 9 □ Unknown		9□Unki											
Records, P.O.	gned be det	by Р	Part II. Other significant co	onditions co	ontributing to	death but not	resulting in th	e underlying c	ause given	in Part I.			- 4			cause of death?
	been signe should be										_	1 🗆	Yes 2	No 3	] Probabi	ly 4 Unknown
<b>Hecords</b>	hes b	Completed										24a. Wa auto	s an opsy ormed?	24b. Were prior death	autopsy to comp	y lindings available letion of cause of
		e Co	25. Was case relerred to n	nedical						ne Place	of Dooth	1 ☐ Yes (Check only	2 No		/es 2[	□ No
	this certific al director,	To B	examiner? 1 ☐ Yes 250 No	-	Hospital:	Inpatient	2 ER/Outpa	tient 3 DC	Other			ne 5 Res		Other (5	Specify)	
	Viter thuneral		27. Manner ol Death 1 Natural 5 ☐ I	Pending		of Injury of Day Yea	28b. Tim Inju		8c. Injury a Work?			8d. Describe	how injur	occurred		
DIVISION	death ctor: /	licat	3 ☐ Suicide 6 ☐ 6	nvestigation Could not be	.	e of Injury	At home, larm	M street lactor		es 2 🗆 N		RI Location	(Street an	d Number o	Rumin	Route Number,
2 5	Director of the b	Certification:	4  Homicide	determined	build	ding, etc. (Sp	ecify)	Street, lactor)	, onice			City or To	wn, State	)	71070771	oute reamon,
Underline of	within 24 hours efter death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 17 Ce	rtifying Ph	ysician: To the	e best of my	knowledge, d	eath occurred	at the time	, date and	d place, a	nd due to the	cause(s)	and manne	r as state	ed.
Tother	the F mplete	Medical	one) 29b. Signature and title of		and ma	ner stated.	Timation arias		. License r			o at the time		e signed (M		
, F	¥ <b>⊢</b> 8		A A	(X	10	n:		7	430	777	,		Cil		4	2001
			30 Name and address of p	erson who	completed cau	se of death	(Item 23a) (Ty	pe, Print)	137	1/		mo	3 Ar	When		
	12		Charles On	etu	3. S	0/ 1-10	En Zu	Don	e, C	ilon	30	me	m	5-5	106	1.
	Sta Registr		31. Date filed (Month, Day,		2006 32.	egistrar's S	gnature	South	0							
			OLI	4 4 6	-555		100									

			1 - For State Registrar	State of Ma	ryland / Der	partment of learning	Health and	Mental Hygie	ene 2 0 0 6	30214
			Decedent's Name (First, Middle, Last)				Dodin			3. Time of Death
	Physicia								4:30 P M	
	/Medic Examin		4a. Fecility Name (If not institution, gi			4b. City, Town, o	or Location of Deat		4c. County of Deat	
		и	360 01d E1k Necl	k Road		North			Ceci1	
	Funeral			Sex 7. Age 1 ☐ M 2 💢 F	(In yrs. last birthda	// If Under 1 Year Months Days			ear) 9. Birt	hplace (Stete or Foreign ountry)
	Director		218-18-8097 Usuel Residence of Decedent		95 Yrs.			Oct. 3,	1910 Nort	h East, MD
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show out, the Medical Examiner must be notified at		10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
		tor	Maryland Cecil		North Ea	st				1 □ Yes 2 🙀 No
		)ire	10e. Street and Number		1101 111 114	10f. Zip Code		10g	. Citizen of What Co	ountry?
		rai	360 Old Elk Necl	k Road		21901		Un	ited Stat	es
		une	11. Marital Status	12. Was Decedent E Armed Forces?		. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by Funerai Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	1 ☐ Yes 21 No	Specify:		Specify: Wh	ite
21215-0036	2 hou	ted	15. Decedent's I	Education	16a. Dec	edent's Usual Occup	pation	. 16	b. Kind of Business/	
215	thin 7 8. an "n Med	Completed	(Specify only highest g	rade completed) College (1-4or 5-	life	e kind of work done DO NOT use retire	during most of wo ad)	orking		
7	ed wil	Con	7			mbly Line			Firewor	ks
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.	Be	17. Father's Name (First, Middle, Las					me (First, Middle, Mai	iden Sumame)	
$\frac{8}{5}$		우	John R. Keithley  Mary Dougherty  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Ma			19a. Informant's Name/Relationship Edna Hamilton /			_		, North Ea:		
			20a. Method of Disposition	Daughter		position (Name of ematory or other pla			c. Location - City or	
Baltimore,			1 Burial 2 Cremation 3				1	12 2006 1	Nouth Ess	. Want 1 1
票	mit. F portar r inju		'4 Donation 5 Other (Specify) Hart's Cemetery Sept. 12,2006 North East, Maryland 21. Signature Funeral Arvice County Funeral Home							
m	Depariming Department of the sany ir the s		Y/2014 C	-				reet North		21901
	Priysician /Medical Examiner	by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Onset and Death  METASTATIC COLON CANCER  Due to (or as a consequence of):							
			Sequentially list conditions,	b. Due to for as a	a consequence off:					
			if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.							
<u>,</u>										
760,	ite be iysicia ne bur									
68	rtifical ng ph		IS SERVALE.						1	
õ	es that the death certifica igned by the attending ph be detached for use as th		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown				opic pregnancy		23d. Date of deli Month	ivery Day Year
Ö.	the at							mani bay tal		Day
<u>o.</u>	hat the ed by detac	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?						the cause of death?	
Division of Vital Records, P.O. Box 68	signe signe							2 1 No 3 Pr	obably 4 Unknown	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	iete				24a. Was an 24b. Were autopsy findings available		topsy findings available		
Re		Completed	GASTED AFTHRITIS GASTED ESOPHAGEAL REFLUX DISEASE			autopsy prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No				
ta		Be C	25. Was case referred to medical	GEAL REFLY	CK DISEAS	<u> </u>	26. Place of De	ath (Check only one)	110	20110
>		Medical Certification: To B	examiner? 1 🗀 Yes 2 🗗 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpati	ent 3 DOA Ott	her: 4 \( \text{Nursing } \)	Home 5 Hesidenc	e 6 □Other (Spec	cify)
n o										
sio			2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 399 Blace of Injury 4t home farm street feetons office.						10	
$\overline{\leq}$			28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		iral Houte Number,		
_			29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
			(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the within 2 To the complet		29b. Signature and title of certifier		29c. License number			29d. Date signed (Month, Day, Year)		
)			4 M.D.			D007	17711	5	eptember	11,2006
	11		30. Name and address of person who				#			
	T		31. Date filed (Month, Day, Year)	304-306 N	orth Str	ut Suite	-3 FLI	KTON MAK	(LAND SI	431
State Registrar SEP 1 1 2006 State SEP 1 1 2006										

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Sept Physician Charles Galen Kenney, Jr. 2006 10:00 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Hosp Baltimore Specia moversilly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months 15₹M 2□F Director 032-12-8215 80 3/10/1926 Maine Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Iteme 23a or 28e-1 show other treumatic event, the Medical Examiner must be notified at Director 1)X Yes 2 □ No Prince George's Forestville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2702 Lorring Drive 20747 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 □ Divorced Year or Dates: 1948-68 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Galen Kenny, Sr. Henrietta L. Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Kenney Doan/Daughter 3108 Lee Shore Loop, Orlando, Florida 32820 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/9/2006 Beltsville, MD 22. Name and Address of Facility Raymond-Wood Funeral Home, P.A. 21. Signature of Funeral Service Licensee PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SE PSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine transit The law requires that the death certificate be executed ENCEPHALOPAHY ANOXIC Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760 CORONARY DISEASE Physician/Medical ARTERY IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ MABETED MEMINS 1 Yes 2 No 3 Probably 4 Unknown Completed DECUBITUS SAZRUM ULCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? DERIPHERAL VASCULAR certificate DISE ASE 1 🗌 Yes 1 ☐ Yes 2 Ø No Division of Vital 2 🗹 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) ATTENDING D0058948 SEPT. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE BALTIMME 21214 GUITE 3H MD IAN SINDA MD 300 ARMORT 32. Registra Signature 31. Date filed (Month, Day, Year) State SEP 7 2006 Registrar

senney,

State of Maryland / Department of Health and Mental Hygiene 200630216 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** King 4:08 P M Cecelia Donna August 28, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Frederick

If Under 1 Year | If Under 24 Hrs. | 8. D

Months | Days | Hours | Min. | (// Calvert <u> Calvert Memorial Hospital</u> Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 27 F Yrs. Director 214-40-9600 63 Feb 18, 1943 Wash., D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or itame 23a or 28s-f show sumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Calvert Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Ray Road 20689 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be t and Mental I Elizabeth Mario John Mary Hanrahan ဥ Leone 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health P.O. Box 83, Sunderland, MD 20689 <u>Richard J. King, Jr., spoușe</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If its eny injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Harmony Cemetery 09-01-2006 Owings, MD 21. Signature of Euperal Service Licensee 22. Name and Address of Facility William Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Obstructed Air Passages /Medical Due to (or as a consequence of): Examiner Inoperable Carcinoma of the Parotid Gland Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be executed es the burial-transit Exami and Invading the Trachea resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien for use es the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a detached f 1 ☐ Yes 2 X No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate 1 ☐ Yes 2 🗓 No 1 Yes 2 No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☒ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No narel Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funarel Dire ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Mal D 12705 August 31, 2006 30. Name and address of person who completed cause of see th (Item 23a) (Type, Print) 1050 Solomons Island Road, Prince Frederick, MD 20678 Emad Al Banna, M.D. 31. Date filed (Month, Day, Year) 32. Registra Signature State SEP 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month August, Day 26, 2006 Physician Kent Sr. James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick **Calvert County Nursing Center** Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 F 578-38-1616 Yrs. Director 86 Jun 11, 1920 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinational Examination of 2008. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Calvert **Owings** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 386 Skinners Turn Road 20736 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 194 If Yes, Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1941 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 1946 Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Laborer 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lelia Coates Issac Freeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Jewett Place Bowie, MD 20721 James B. Kent, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/31/06 Sunderland, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UM Church Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Glady Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? lens, on 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has birector, page 2 s 1 Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 HO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No naral Diractor: A filled in by tha fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Funaral 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

- 25435 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukesh Mathur, M.D. Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 2006 Registrar

			1 - For State Registrar		ryland / Depa <i>Cei</i>	artment of H rtificate of L			Reg. No.200	6 30218
	Physici /Medic		Decedent's Name (First, Middle, Las     SOON OK LE	,				2. Date of De. Month SEPT	9, Day 2006	3. Time of Death 10: 23 MAN
	Examir		4a. Facility Name (If not institution, give	N LN		4b. City, Town, or  DERWOC  If Under 1 Year			4c. County of D	OMERY
	Funeral Director		5. Social Security Number 6. Sec	ox □M2ŽIF	(In yrs. last birthday) 72 Yrs.	Months Days	Hours Min	. (Month, Da	y, Year) 17,1933	Birthplace (State or Foreign Country) S KOREA
	ith the Maryland or 28a-1 show	Director	10a. State         10b. County           MD         MONTGO           10e. Street and Number		10c. City, Town or Lo				10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23a or	i Di	7629 MOCCASIN	LN		2085	55		USA	Countrys
9003	s 1 and 2 should be filad within 72 hours after death with the Maryland I Health and Mental Hygene. I Health and Mental Hygene. Item 27 is marked other than "naturel", or Itams 23a or 28a-1 show other treumatic event. The Marical Examinational Propositional at	d by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Endemed Forces? 1 ☐ Yes 2 ☐ Notif Yes, Give Year or Dates:	)	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2[X]No	spanic Origin? ( n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		
21215-0036	within 72 h lene. than "nate the Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1.2		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wo	orking	16b. Kind of Busine	
b	Hygie other	a)	17. Father's Name (First, Middle, Last)			JODHWIT E		me (First, Middle,	Maiden Surname)	
Maryland	2 should be filad within and Mental Hygiene. is marked other than eumatic event, the M	To B	WOO SIK KIM  19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street a	YOUN		PARK ar, City or Town, State	a. Zip Code)
	1 and 2 : Health ar Iem 27 is		BRYAN LEE / S	ON		5 CITRU				
nore,	00		20a. Method of Disposition 1 Rurial 2 Cremation 3	Removal from State		natory or other place		Date	20c. Location - City	
3altimore,	parmit, Pag Department Important; I any injury o		4 ☐Donation 5 ☐ Other (Specify 21. Signature of Funeral expire Licen			K MEMORI  Name and Addres	o of Engility	13/06 HARLES	OLNEY HINDS FU	MD JNERAL SERV
	70 = e d		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused to	he death. Do not ent					MD 20772 Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. metas	consequence of):	concer o	Cerr	nt		Onset and Death
8760,	rate be axecuted hypsician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate caues. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):	11.7				
O. Box 6	death certific e attending p d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of a	Jelivery Day Year
rds, P.	es tha igned be de	by	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		to the cause of death?  Probably 4 □Unknown
Il Records,		Completed							osy prior t rmed? death	autopsy findings available to completion of cause of ? es 2 No
Vital	iclen certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Othe		ath (Check only o		
of	ling After Fune	tion; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28c. Injury Work	at at		dence 6 Other (S	pecify)
Division	in Diffe	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of iner: On the basis of e and manner state	xamination and/or in	occurred at the tim vestigation, in my op	e, date and plac inion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated, tue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	uB-	m	29c. License	number 646 15		29d. Date signed (Mg	onth, Day, Year)
R	(2)		30. The and address of person who co			- I bear		Re	daville	mo
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 2 2006	2. Registrar	's Signature	W				

			For State Registrar	State	of Maryland		artment of H		nd Mental H	lygien Reg. Ne	71116	30220
			1. Decedent's Name (First, Middle	e, Last)					2. Date of	Death		3. Time of Death
ı	Physici /Medio		ROBE	RTA	LAN	DE	5		SEPTE	MBER	03, 200	6 5:10 A M
7	Examir		4a. Facility Name (If not institution	-			4b. City, Town, or	r Location of	Death	40	c. County of Dea	th
			Hebrew Home of				Rockvill			1	Montgome	ery
	Funeral Director		5. Social Security Number 216–38–5958	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month,	Day, Year	)   _ C	thplace (State or Foreign ountry)
			Usual Residence of Decedent		68			<u></u>	SEP 7	, 19.	37 D.0	<b>.</b>
	yland how		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	e Maria-1 s	ctor	Maryland Montgo	mery	Rock	ville	!					1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	ountry?
	s 23a	rai	6111 Montrose R	1		1.5	20852				ted Stat	
	Ifem Iner	-une	11. Marital Status  1 ☑ Never Married 2 ☐ Mar	Armed F	cedent Ever in U.S. forces? 2 XNo		Was Decedent of H If Yes, specify Cuba	ispanic Orig an, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White	
980	urs al	by	3 Widowed 4 Divorced	IT YAS (S	ive		1 ☐ Yes 2 🛣 No	Specify:			Specify: Whi	to
2	be filed within 72 hours after death with the Maryland tial Hygiene.  do other than "natural", or flems 23a or 28a-1 show event, I're Medical Exertiner must be neithed at	Completed by Funeral	15. Deceder	nt's Education	1	16a. Dece	dent's Usual Occupa	ation	of working	16b. F	Kind of Business	
7	ithin ne.	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	d)	or working			
7	Hygien Hygien Ther ti	ပိ	12 17. Father's Name (First, Middle,	/ act)		Key	punch Ope		's Name (First, Midd		ASA	
Maryland 21215-0036	d be f antal h	Be c	Nathan Taube La	ŕ				Sara	S Name (First, Mice	ne, maigei		
2	should mark matic	은	19a. Informant's Name/Relations			19b. Maili	na Address (Street a		or Rural Route Nur	nber. City	Reff	Zin Code)
S	nd 2 salth ar 27 ls		Jeff Landes/Bro						Somerse			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is merked other than "natural; or items 23a or 28a-1 show eny intry prother treumatic event, It's Madical Examinar must be nutified at once.		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of matory or other plac		Date	-	ocation - City or	Town, State
Ē	Page nent c		1 ☐ Burial 2 🕅 Cremation • 4 ☐ Donation 5 ☐ Other (S		State	-	•	,	/7/2006	Re1	tevillo	Maryland
at	ppartri porte iy inju		21. Signature of Funeral Service	Licensee		2: T'	2. Name and Addres	ss of Facility	ry Servic	D D	A	ratyrano
_	907 29		ful!	nue-	M00956	9.	33 Gist Av	ve., L	L, Silver	Spr	ing, MD	20910
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on							-	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)	_aCO	NGES	TIV	EMERA	et t	BILU	RE		Onset and Death
	/Medical Examiner		rosuming in additio	Due to	(or as a conseque		- nra	11/1	DISER	سر ی در		
		er	Sequentially list conditions, if any, leading to immediate	bDue to	(or as a conseque		= KON	ML	DISTE	100		
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .								
oʻ	a exec an an rial-tr		resulting in death) Last	Due to	(or as a conseque	nce of):						
8760	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d								
9	ertific ding p		IF FEMALE:	220 16 1100 01								
Box	eath certifi attending   I for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregnanc birth 2 D Fetal de mant at time of deal	eath 3[	Ectopic pregnancy Other (specify)			1	23d. Date of del Month	ivery Day Year
o.		ysic	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unkr		ui 5L						
٥.	The law requires that the tee has been signed by thoage 2 should be detache	by Physician/Me	Part II. Other significant condition					en in Part I.	23e. Di	d tobacco	use contribute to	the cause of death?
rds	w requires been sig		ARTERIA	- HYPE	ERTEN	510	N		1[	Yes 2	<b>b</b> No 3□Pr	obably 4 Unknown
Records,	awre	plet							24a. W		24b. Were au	utopsy findings available completion of cause of
		Completed							pe 1 ☐ Yes	topsy rformed? 2 12 No	death?	1.7
Vita	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medica examiner?					26. Place o	of Death (Check onl)			
<del> </del>	this at dii	၉	1 1 Yes 2 No			VOutpatier		#   IAMIS	sing Home 5 Re			crfy)
UC.	ing Vftei une	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	19	of Injury oth, Day Year)	8b. Time o Injury	Work	≀at ⟨? Yes 2N	28d. Describ	e how inju	ry occurred	
Division	Attending ir death. ector: After by the fune	fica	2 Accident investig	not be	e of Injury - At home	e, farm, str		163 2010		(Street ar	nd Number or Ru	ıral Route Number,
	i Pite o	Certification:	4 Homicide	build	ting, etc. (Specify)	, , , ,	, , , , , , , , , , , , , , , , , , , ,		City or 7	own, State	9)	
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the to		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physicien: To th	e best of my knowle	edge, deat	occurred at the tim	ne, date and	place, and due to th	e cause(s	) and manner as	stated.
	To the He within 24 To the Fr	ledical	one)		nner stated.	n and/or in			occurred at the tim	e, date an	d place, and due	to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifie	' I	1/10-	11	29c. License				te signed (Monti	
	3		Bowbar	ue de	way	1 17:1	V. V 53	736		TE PI	TEMBER	03,2006
			30. Name and address of person	who completed cau	se of death (Nem 2	3a) (Type,	MONTO!	X.F.A.	DAN DA	1/1//	115 1	03,2006 D 20852
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Signatur	( U /	11001120	10 K	NITY, KUC	KV/	UUU) M	DEUSJE
	Registr		SEP -	8 2006	gistrar's Signatur	x A	sere					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

30221

			For State Registrar			viai yiai		rtificate of			Reg. N		3022
	nysicia		1. Decedent's Name GEORGIA 1		ast)					2. Date of Month	D	3 2006	3. Time of Death 7:50 A M
3	Medic xamin				ve street and number	er)		4b. City, Town,	or Location of D			c. County of Death	
			GENESIS I	LAYHILL (	CENTER			SILVER	SPRING		MO	ONTGOMERY	7
Fui	neral		5. Social Security N			Age (In yrs.	last birthday	Months Days		Vin. (Month	f Birth i, <i>Day</i> , Yea	9. Birth	nplece (State or Foreign untry)
Dire	ector	-	226-18-64	410	1□M 2 <b>X</b> F	85	Yrs.			01/25	5/1921	VIRG	IŃIA
pur s	227	}	Usual Residence of 10a. State	10b. County		10c. Ci	ity, Town or L	ocation					10d. Inside City Limits
Aaryli	8 2 8	5			7777								1 ☐ Yes 2 <b>X</b> No
the A	illin	Director	MD 10e. Street and Nur	MONTGOM	SKY	SII	LVER SI	PRING 10f. Zip Code			100.0	Citizen of What Cou	unto/2
with	3	흡										JUZBITOL WITAL COL	and y :
eath	Tales	era	3227 BELI	PKE KUAD	12. Was Decede	nt Ever in U	J.S. 13.	20906 Was Decedent of	Hispanic Origin	? (Specify Yes o	USA or No-	14. Race - Amer	ican Indian.
fter d	age.	Funeral		ied 2 ☐ Married	Armed Force	s?		Was Decedent of If Yes, specify Cu		uerto Rican, etc	.)	Black, White	
	Evan	by	3 🗷 Widowed	4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 🛣 No	Specify:			Specify: WH	ITE
1215-0036  within 72 hours after death with the Maryland ener.	Ical	Completed	/Sana	15. Decedent's E	Education		16a. Dece	edent's Usual Occu e kind of work done DO NOT use retire	ipation	working	16b.	Kind of Business/l	
212 Thin 7	Med	pie	Elementary/Seco	, , , ,	College (1-40	or 5+)	life.	DO NOT use retir	ed)	working			
filed will	2	Son	8				LANDI	ORD			REA	AL ESTATE	1
be filed tal Hygin	NB/	Be (	17. Father's Name	(First, Middle, Las	t)				18. Mother's	Name (First, Mi	ddle, Maide	en Sumame)	
yla ylani Meni	atic	ို	IKE LEONA	ARD					NITA C	OOPER			
Maryland 21215-0036  d 2 should be filed within 72 hours at th and Mental Hygiene.	other traumatic event, the Medical Examinst must be notified at		19a. Informant's Na				11				-	or Town, State, Zi	p Code)
t and Health	Jer fr		NANCY BAI	<del></del> _	JGHTER	1	- Andrew Control of the Control of t	WAN COVE	LANE,		-		
Ore of H	r of		20a. Method of Disp		Removal from Sta		Place of Disp cemetery, cre	osition (Name of matory or other pl	асе)	Date	20c.	Location - City or T	own, State
Pages ment of	ury		* 4 ☐ Donation	5 Other (Spec	i(y)		ESAPEAI	KE CREMAT	TION 09	/05/06	STE	VENSVILLI	E, MD
Baltimore, permit. Pages 1 at Department of Hea	any injury or other once.		21. Signature of Fu	neral Service Lie	ensee		F	2. Name and Addr	ess of Facility	IN & NEX	JNAM 1	FIINERAT. H	IOME, P.A.
m g05	i 0			asse (	200	_	10	06 SHAMRO	CK RD.,	CHESTE	R, MD	21619	
			23a. Part1. Enter	he disease, or cor n failure. List ont	nplications that cause on each	sed the dea Line.	th. Do not en	ter the mode of dy	ing, such as care	diac or respirato	ry arrest.		Approximate Interval Between
Physi	ician		Immediate Cause ( disease or conditio			Jan	cre	atic	Carc	inoma	9		Onset and Death
	dical		resulting in death)	(	Due to (or	as a consec	quence of):						
Exam	imer		Sequentially list nor	nditions	b		3 >	,					
70	sit	Examiner	Section tially list not if any, leading to im cause. Enter Unde Cause (Disease or	nmediate orlying	Due to (or	as a consec	quence of):						
ecute and	tran	Саш	that initiated events resulting in death) t		C. Due to for	as a consec							
50, 8 ex	urial	<u> </u>			Due to (or :	as a consec	quence or):						
68760, ifficate be executed or obvision and	the	edical			d								
	should be detached for use as the burial-transit	Me	IF FEMALE:	-	23c. If yes, outcor	ma of orago	2001						
Bo ath a	lor us	ian	23b. Was decedent in the past 12		1 Live birth	2 Feta	al death 3	Ectopic pregnant	су			23d. Date of delive	very Day Year
O 8 8	hed	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant 9□ Unknowr		Jeath 5	Other (specify)			_		
F at the by	detac	by Physician/M	Part II. Dther signif	icant conditions	contributing to death	h but not res	sulting in the u	inderiving cause g	iven in Part I	23e. I	Did tobacco	use contribute to	the cause of death?
ds,	d be	d b		/	) emen	-	•	,,,			I □ Yes		
Ped Legal	houl	Completed		Person	7.7.	7				_	-		
Sec e law	19.2	ם								_   a	Mas an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
<u> </u>	pag									1 🗆 Y			2 No
Vita ician	ector	Be	25. Was case reference examiner?		Hospital:			0	thor	Death (Check o			
Phys of	al dir	٦.	1 ☐ Yes 2 ☐ 27. Manner of Deatl		1 _ Inpa		ER/Outpatie	RE 3 DOA	4 Nursin			6 ☐Other (Speci	fy)
Division of Vital Records, P.O. Box for Attending Physician: The law requires that the death cer after this carrifcals has been sinned by the altendir Director at	luner	io	1 Natural	5 Pending	28a. Date of In (Month, I	Day Year)	Injury	W		280. Descr	ibe now inj	ury occurred	
ISIC Itend	the	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6  Could not l	be an Place of	Injune At h	omo form et		]Yes 2 □No	29f Locati	on /Etrant	and Number or Du	rol Bouto Alumbar
or At	in by	Certification:	4 Homicide	determined	280. Place of	etc. (Speci	fy)	reet, factory, office	•	City of	Town, Sta	and Number or Rui te)	al Houte Number,
pital purs a	liked		20a Cartifics	10 Cardifular D	businism. To the be	at of my lan	audadaa daa	No		to a seed door to			
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. After this cartificate has been singed by the attending to the attending to the attending the structure of the structure	completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)	2 Medical Exa	hysicien: To the be miner: On the basis and manner	s of examina	ation and/or in	n occurred at the twestigation, in my	opinion, death o	ace, and due to occurred at the ti	ine cause( me, date ai	s) and manner as: nd place, and due:	stated. to the cause(s)
thin 2	omple	Mec	29b. Signature and	title of certifier	and manner		37	29c. Licer	ise num er		29d. D	ate signed (Month,	, Dey, Year)
F ₹ F			▶ X /(	1 .	AHOUR	Oinl	phy.	Stevens	D5	3648		0	no K
304	,/	1	20 Name 25	Jul.	completed same	d don't	V /	Print)			100	1. 32	000
CIL	1		Su. Name and addr	ess of person who	completed cause of	J J J J J J J J J J J J J J J J J J J	L De	Ravs	1 B/VC	1 30	3 8	altima	e 21239
	Sta	te.	31. Date filed (Mon			strar's Sign	ature	, , , ,			,		- 1 /
R	egistr:		S	EP - 6 2	006	w .	K de	and)					
DHMH 17 I	Rev 1/20	001					7						

			1 - For State Registrar	State of Maryla		artment of F			giene Reg. No. 20	06	30	222
	Physici		1. Decedent's Name (First, Middle, La Joseph	st) Edward	I	Lewis		2 Date of Dea			3. Time of 1:40	f Death
	/Medic Examir		4a. Facility Name (If not institution, giverally 2538 Maytime Dr			4b. City, Town, o	r Location of Dea		4c. County			
į	Funeral Director		5. Social Security Number 6. S 578-60-3223		rs. last birthday) 57 Yrs.		If Under 24 Hrs Hours Min				lace (State o	or Foreign
	he Maryland 8a-f ehow billied at	ector	Usual Residence of Decedent  10a. State 10b. County  MD Anne Ar		City, Town or Lo	l1s					0d. Inside Ci 1 ☐ Yes	•
	th with the 23a or 2	al Dire	10e. Sfreet and Number 2538 Maytime Dri	.ve		10f. Zip Code	21054		10g. Citizen of \ U	What Coun SA	try?	
036	d within 72 hours after death with the Maryland Jiene. r then "natural", or Iteme 23a or 28a-1 ehow Itte Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates: 196		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※XXNo	lispanic Origin? ( an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	ce - Americ ck, White, e		
9500-91212	thin 72 e. en "nai	Completed	15. Decedent's Education (Specify only highest grade) Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of B		•	
yland 2	ould be file Mental Hyg arked othe	To Be Co	17. Father's Name (First, Middle, Last, Ralph E. Lewis			-0		me <i>(First, Middl</i> e, Iazel Ant	Maiden Surnan			
е, маг	l end 2 sh lealth and im 27 is m her traum		19a. Informant's Name/Relationship ( Gloria Lewis (W: 20a. Method of Disposition	ife)		Maytime				.054		
altimor	8 2 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)	Removal from State	etro Cr	matory or other place	·		Baltimo			
מש	permit. Par Depertmen Importent: eny injury o		21. Signature of Funeral Service Licer	asee MA	22	2. Name and Addre Hardesty 12 Ridge	Funeral			D 214	01	
8/00,	Certificate be executed  Ex  Medical  Mind physician and  See as the burial-transit	dical Examiner	23a. Part1. Enter the disage, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf	b. Due to (or as a cons  Due to (or as a cons  Due to (or as a cons  C. Due to (or as a cons  d.	equence of):	er the mode of dyin		c or respiratory and			Approximate Interval Betwoonset and C	ween
DOX O	death certii e attending d for use a	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fr 4 □ Pregnanf at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)				te of deliver	-	/ear
cords, P	w requires that the de been signed by the a should be detached i		Part II. Other significant conditions of	ontributing to death buf nof r	esulting in the u	nderlying cause givi	en in Part I.		bacco use conti es 2 □ No	nbute to the		leath?
uec u	The law ate has b page 2 sl	Completed						24a. Was a autop: perfor	med?	Were autop prior to com death?	osy findings a npletion of ca 2 No	available ause of
Vital	ysician: Th s certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	ot 3 DOA Oth		ath (Check only or Iome 5 Resid		or (Specify	1	
IVISION OF	To the Hospital or Attending Physician: whip 24 hours after deals at the Funerel Director. After this certifica completely filled in by the funeral director,	ertification: T	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28c. Injun Work	/at <br Yes 2□No	28d. Describe h	ow injury occurr	red		
	spital or A ours after or nerel Direc filled in by	ပ	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe			ne date and place	28f. Location (S City or Town	n, State)			ber,
	To the Ho within 24 h Fo the Fur completely	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of exami and manner stated.	ination and/or in	vestigation, in my of	oinion, death occi	urred at the fime, d	ause(s) and ma late and place, a 29d. Date signed	and due to	the cause(s)	
			30. Name and address of person who	A DOLL	Q JU (	N DOO	17961	MO	9-5	2	206	
5			Oscar A. Farias,	MD 1667 Cro	ofton Ct	re, Ste	l, Croft	on, MD 21	1114			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Sig	nature	South o						

			1 - For State Registrar	State of	Maryland		artmen rtificat					giene 0	06	30223
	Dhysia		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea		Year	3. Time of Death
	Physici /Medi		Grace Marie Li								Septemb			7:40 A M
	Examir	ner	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death	_	4c. Count	ty of Death	
			Calvert Memoria 5. Social Security Number			6146 1 1	Pri If Under		Frede					County
	Funeral Director		072-22-4853	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. last	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	r, Year)	9. Birth	place (State or Foreign ntry)
			Usual Residence of Decedent					j			Oct. 5,	1928	New	York
	ırylan show	L	10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	88-f s	cto	MD Calvert	County	Dunk	kirk								1 ☐ Yes 2X No
	vith th	Director	10e. Street and Number				10f. Zip					10g. Citizen of		ntry?
	s 23g	eral	3125 Lyons Cree		dent Ever in U.S.	10		754		1.0.10	7 1	U.S.		
10	fter d ritam insr	Funeral	11. Marital Status 1 XNever Married 2 Marrie	Armed For	ces?	13.	If Yes, spec	ent of Ha	n, Mexican	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)		ce - Americack, White,	
036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	0		1 ☐ Yes 2	No No	Specify:			Speci	ty: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Modeul Examinat has be notified at	Completed	15. Decedent's (Specify only highest	Education	11	6a. Dece	dent's Usua	l Occupa	ition	t of working		16b. Kind of E	Business/In	dustry
21	Atthin ne.	nple	Elementary/Secondary (0-12)	College (1			kind of wor DO NOT us				'g			
	be filed within 72 hours after death with the Marylan that Hygiene. Ind other than "natural", or itams 23a or 28a-f show a other than "natural", or itams 23a or 28a-f show avent, the Modred Examities must be notified at		12 17. Father's Name (First, Middle, Li	act)		Edit	orial	Ass			(Fig. 1, 1)			ompany
Maryland	should be filed withir of Mental Hygiene. marked other than matic avant, the Mental Mental of Me	Be	James Lizzio, S								(First, Middle, e Bei	Maiden Suma	me)	
Z	should be and Mental Be marked o	2	19a. Informant's Name/Relationshi		1	I9b. Mailir	na Address	(Street a			Route Number	City or Town	State Zin	Code)
Š	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic as <u>once</u> .		Marilyn Lizzio											
Baltimore,	s 1 a of Hez itam othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Nam natory or ot	e of	CCK I	Da	Dunkir	20c. Location	- City or To	own, State
E	Page nent c int: If		1 X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (See	3 □Removal from S ecify)	South					Sept.	9.	Dunkir	k. Ma	rvland
alti	ermit. spartn sports iy inju		21. Signature of Fundamental	cens		22	. Name and	d Address	s of Facility		000		•	ert, P.A.
_	90 E 29		Michael W/I	ee Cu		8	125 S	outh	ern M	arvl	and Blv	d. Ow	ings.	MD 20736
			23a. Part1. Enter the disease, or a shock, or heart failure. List or	omplications that can nly one cause on ea	ich fine	Do not ent	er the mode	of dying	, such as	cardiac or	respiratory arr	est,	0	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	PNE	41	SON	17						Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	or as a consequent	ce of):								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequenc	ce of):								
	uted d ansit	Examin	cause. Enter Underlying Cause Unisease or injury that initiated events											
oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (d	or as a consequenc	ce of):								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dlcal		d										
9	artifice ing ph e as t	Med	IF FEMALE:											
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	ome of pregnancy th 2 Petal dea		Ectopic pre						ite of delive	7
0	the de y the a sched f	Physiclan/Me	1 ☐ Yes 2 ₩ o 9 ☐ Unknown	4□Pregna 9□Unkno	int at time of death wn	5 [	Other (spe	ecify)				IVIC	211(11	Day Year
σ.	res that the di igned by the be detached		Part II. Other significant condition	s contributing to dea	ath but not resulting	g in the ur	deriving ca	use give	n in Part I.		23e. Did tot	pacco use con	tribute to th	ne cause of death?
Records,	requires that een signed b hould be deta	d by		Breus	+	-	vce					s 2 No	3 ☐ Prob	-
S	> 0 0	lete					*				24a. Was a	n 24h	Were autor	psy findings available
Be	0 5 0	ompleted									autops	y ned?	prior to cor death?	npletion of cause of
Vital	ician: Th	Se C	25. Was case referred to medical						26. Place	of Death	1 □ Yes 2 Check on on		1 🗆 Yes	2 L No
_ \	ys diis	To B	examiner? 1 ☐ Yes No	Hospital:	patient 2 ☐ ER/0	Outpatien	3 DQ/				e 5 ☐ Reside		ner (Specify	·)
n of	ter Ter		27. Manner of Seath 1 → Natural 5 → Pending	28a. ate of (Month)	Injury 28b	. Time of Injury	28	le. Injury Work	at ?		3d. Describe ho			
sio	Attanding r death. Bctor: After by the fune	cati	Accident investiga				М	1 🗆 Y	es 2 🗆 N					
Division	or Al after of Direction by	Certification:	4 Homicide determin	ad 286. Place	of Injury - At home, g, etc. (Specify)	farm, stre	et, factory,	office		28	3f. Location (Sti City or Town	reet and Numb I, State)	er or Rura	Route Number,
_	spital ours naral filled		29a. Certifier 1 Certifying	Physician: To the t	est of my knowled	da death	occurred a	t the time	date and	d place, ar	od due to the es	usc/s) and me		
	a Fur	edical	(Check only 2 Medical Ex	aminer: On the bas	sis of examination a	and/or inv	estigation,	in my opi	nion, death	h occurred	d at the time, da	ate and place,	and due to	the cause(s)
	To the Hospital or Attanding F within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	10	0		29c.	License	number		25	d. Date signe	d (Month, L	Day, Year)
			1 Joses	1014	act2			1	00	52	247	91	2/	06
	5		30. Name and address of person wh	no completed cause	of death (Item 23a	a) (Type, I	Print)		V -					
	<u> </u>		J. John Barth,	III, M.D.			al Ro	ad,	Princ	e Fr	ederick	, Mary	land 2	20678
	Sta Registr	- 1	31. Date filed (Month, Day, Year) SEP	5 2006	gistra s Signature	K	dea	120						
					1		La July							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 - State Registrat 30224 Certificate of Death 2. Date of Death Decedent's Name (First Middle Last) 3. Time of Death Month **Physician** 27 Dorothy August 2006 5:30A M Mae Larson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bowie
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
April 10 1930 Larkin Chase Nursing Center Prince George's 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 1 1 F Yrs. Director 577-42-7970 76 Maryland Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Machical Examinar must be notified at 1 ☐ Yes 2 No MD Calvert Dunkirk Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20754 United States 3618 Yellow Bank Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural" "" ony injury or other traumatic events." Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emil Larson Mary Louise Merritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Larson, Son 3618 Yellow Bank Road, Dunkirk, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Chesapeake Highlands | 09-02-2006 Port Republic, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of runeral Service L. ensee 22. Name and Address of Facility Rausch Funeral Home, PA Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Respiratory Failure disease or condition resulting in death) /Medical Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ cate has been significated be page 2 should be General Debility 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed Failure to Thrive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes Depression 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely within 2 To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) August 29, 2006 D0045217 30. Name and address of erson who impleted cause of death (Item 23a) (Type, Print) M.D. 6201 Greenbelt Rd. #U-15 College Park MD 20740 Adebowale Ajayi 31. Date filed (Month, Day, Year) 32. Registra/s Signature State Gran & Sparke Registrar

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

		. 1	State of Maryland / Dep	ertment of Health a		ene . No. 2006 30226
	Physicia		Decedent's Name (First, Middle, Last)	-	2. Date of Death Month	Day Year 3. Time of Death
25 ·	/Medic	al	Mamie L. Mayfield  4a. Facility Name (If not institution, give street and number)	4b. Cily, Town, or Location of		er 7, 2006 2:30 P.M
	Examin	er	Washington Adventist Hospital	Takoma Park		Montgomery
1 8	Funeral Director		5. Social Security Number 6. Sex 1	Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day, ) 3/18/36	(ear) 9. Birthplace (State or Foreign Country) Lavonia, Ga.
	land w	l ⊢	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation		10d. Inside City Limits
	a-f sho	ctor	Md. Prince George's	Oxon Hill		1 X Yes 2 No
	with the	ā	100. Street and Number 1100 Owens Road	10f. Zip Code 2074		g. Citizen of What Country?  U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show inviting or other traumatic event, The Medical Exam. Detroited an notified at ADES.	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No It Yes, Give Year or Dates:	. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes X No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. African- Specify: American
21215-0036	within 72 ho ine. Ihan "natur in Medical	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most DO NOT use retired) aid		Domestic
д 5	illed v I Hygie other t	Be Co	17. Father's Name (First, Middle, Last)		's Name (First, Middle, Ma	
ylan	ould be Menta arked atic ev	To B	Joe Jones		en Parks	On the Court To Court
Maryland	id 2 sh Ith and 27 Is m traum		Too C Marifield/Con	iling Address (Street and Number 0.3 Meadow Ridge		lville Md. 20721
Baltimore,	Pages 1 ar nent of Hea int: If Item; iry or other		20h Place of Dis	position (Name of	Date 20	oc. Location - City or Town, State Washington, D.C.
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licensee  August W. Ashu	H.S. Washingto 4925 Burroughs	on & Sons Co Ave., N.E., Wa	.,Inc. ashington,D.C.20019
	ş.		23a. Part1 Enter the disease, or complications that caused the death. Do not e shock, or heart lailure. List only one cause on each line.			interval between
在京	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  September 1. September 2. Sequentially list conditions  Sequentially list conditions	Shock Penst Card	ovas culou c	disease
8760,	death certificate be executed estending physicien and estending physicien and estensite for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence ol):  Due to (or as a consequence ol):	Renal	failure	-
P.O. Box 68	death certif le attending ad for use a	Physician/Medical		B □Ectopic pregnancy B □ Other (specify)		23d. Date of delivery Month Day Year
	law requires that the de as been signed by the a 2 should be detached f	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
Division of Vital Records,	0 - 0	Completed			24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death?  ☐ ▶ 1 □ Yes 2 □ No
Vita		Be	25. Was case referred to medical examiner?  Hospital:	Other	of Death (Check only one	
o	Phys rthis raldii	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	rsing Home 5 Resider 28d. Describe how	
ivision	or Attending Physician: after death. Director: After this certific in by the funeral director.	ertification:	1 🗗 Atural 5 Pending (Month, Day Year) Injung 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injuny - At home, larm, building, etc. (Specify)	M 1 Yes 2 N		pet and Number or Rural Route Number. State)
Ω	Hospital 4 hours Funeral ely filled	edicai Cer	29a. Certifier  (Check only one)  One)  29a. Certifier  (Check only one)  Addical Examiner: On the basis of examination and/or and manner stated.			
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
2	1			331 University E	Blvd.,Silver	Spring,Md. 20903
3	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 2 2006	L.		

State of Maryland / Department of Health and Mental Hygiene, 30227 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Year MILLER **Physician** AGNES Μ. 5-5 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDHU 10-.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Manths | Days | Hours | Min. | MAR 25, 19 BALTIMORE CENTER BOSPITAL NOMHWEST 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 🖸 F 222-12-8604 81 Vrs DELAWARE Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or items 23s or 28e-f show the Medical Evartings than the notified at 1 ∑Yes 2 □ No MARYLAND BALTIMORE CITY BALTIMORE CITY Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3508 ELLEN ROAD 21244 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFICE WORKER CLERICAL is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event size. Be WTT.T.TAM HOLSTON SADIE PARKER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRANVILLE L. HOLSTON / BROTHER P.O. BOX 29, MILLSBORO, DELAWARE 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MILLSBORO CEMETERY 9/12/2006 MILLSBORO, DELAWARE \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M80268 22. Name and Address of Facility SON FUNERAL HOME, WASHINGTON ST., MILLSBORO, DE 19966 WATSON 211 WA WATSON FUNERAL HOME.

211 WASHINGTON ST., MILLSBO
23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREAS Physician 01-ADENOCARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit nding physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy 241 No 1 Yes Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 ihis 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Injury 27. Magner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29c. License number 783 PHYSICIAM 29b. Signature and the 29d. Date signed (Month, Day, Year) DNU 07 2006 SEPTEMBER 723WHITACH HOSPITAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARISH. VVERAHALLI m BA 6 5401 COUNT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 1 2006 Registrar

06-06603 John Milling

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 30228

		For State			(	Certifica	ate of	Death			R	eg. No.	S (	0 0	0 302	_
Physician		egistrar . Decedent's Name (First, Middl	e,Last)							2.	Date of Dea	th		3	. Time of Death	$\neg$
Physician Medical Examine				4114.	na						Month Septembe	Day er 3, 200	Year 06		1742 hrs	
woode Examine		John Frankli la. Facility Name (if not institution	11 [V]	TTTT	imber)		Δ	b. City, Town, or I	ocation of				County of E	Death		$\dashv$
	•	Calvert Memorial Hos		street and no	iniber)		17	Prince Frede		Dod			lvert			
											(B)			O. Dietle	1 (0)-1	
<b>Funeral</b>		5. Social Security Number	6. Sex		7. Age (In	yrs. last birt	hday)	If Under 1 Year	If Under	Min.	8. Date of Bi	th(MM/DL		oreign	place (State or	
Director		215-54-6129	1 XN	1 2 F	56		Yrs.	Months Days	Hours	IVIII I.	Aug.	23,			Maryland	
	H	Jsual Residence of Decedent	1.2.7					ll								$\dashv$
any	-	10a. State 10b. County			10c.	City, Town	or Location	on						1	0d. Inside City Limit	ts
≥															1 Yes 2 X	lo l
and sho	٦L	Maryland Calv	ert			Lusby					<del></del>				**	_
Maryland 28a-f show d at once.	ទូ	10e. Street and Number						10f. Zip Code					n of What			
th the Maryland 23a or 28a-f sho notified at once	Director	9790 H. G. Tru	emar	n Road				20657			l	Unite	ed St	cate	S	
s 23	ᅙᅡ	11. Marital Status		12. Was Dec	cedent Ever	in U.S.	13. Was	Decedent of His	oanic Origi	in? (Spec	ofy Yes or No	)- 14			in Indian, Black,	П
ath v	Funeral	1 Never Married 2 XM	arried	Armed F			lf Y€	es, specify Cuban,	Mexican,	Puerto Ri	can, etc.)		White, e	etc.		
er de	리	3 Widowed 4 Div		1 X Yes Yes, Give Ye		<sup>No</sup> nam	1	Yes 2X No	specify:			S	pecify:	Whi	te	
9036 within 72 hours after death wiene. ter than "natural", or items Medical Examiner must be	اھ	15. Decedent's Education (Spe	- 15	or Dates:			-	's Usual Occupati		ind of wo	rk done		nd of Busin	ness/Inc	dustry	
hour natu	Completed			College (				st of working life.				1				Î
27 " re 1 7 2	흵	Elementary/Secondary (0-12)			1-4 OI 5+)	n	(		1/-			1,, 0	Cor	70**	mont	- 1
5-0036 led within 7 tygiene. other than the M dica	ĔĹ			2		Pho	OTO 8	& Graphi					. Gov	/err		_
5-0-6 v Hygi		17. Father's Name (First, Middle	, Last)					1			irst, Middle,		urname)			
21215-0036 Juld be filed within 7 IMental Hygiene marked other than event, the Medica	å	Benjamin H. Mi	llir	ng							Alexar					_
more, MD 21215-0036 Pages   and 2 should be flied within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If tiem 27 is marked other than "natural", or items 23a or 28a-f shu cother traumatic event, the Medical Examiner must be notified at once	의	19a Informant's Name/Relations	ship (Typ	oe, Print )		19	b. Mailing	Address (Street	and Num	ber or Ru	ral Route Nu	mber, City	or Town,	State, 2	≟ip Code)	
nore, MD 21 ages I and 2 should nr of Health and Me It: If iten 27 is ma other traumatic er		Judith E. Mill	inq	(Wife	)	P	. 0.	Box 833	, Lus	by,	Maryla	ind 2	0657			
and and lealth ten	ı	20a. Method of Disposition						tion (Name of cen	netery,		Date	20c. Lo	cation - C	ity or To	own, State	
of H		1 Burial 2 X Crematio	n 3	Removal f	rom State		tory or oth				- /		-			
		4 Donation 5 Other S	pecify:			<u>Metro</u>	poli	tan Crem	atory	9/0	6/2006	ALE:	xandı	cia,	Virginia	<u>a</u>
Baltimore, MD 21215-00. permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Ma	Γ	21 Signature of Funeral Service	License	ee				ame and Address								
ದ ಶನ್ತಿತ್ತ		DIJamo					440	5 Broones	Islan	d Road	l, Port	Repub	lic, M	aryl		
Physician	$\neg$	23a. Part I. Enter the disease, o	compli	cations that	caused the	death. Do n	ot enter th	e mode of dying,	such as ca	ardiac or r	espiratory ar	rest, shock	k, or heart		Approximate Interv Between Onset an	
/Medical	ļ	failure. List only one cause		theroscle	rotic Car	diovascu	ılar Dise	ease							Death	
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)	_	ue to (or as			1101 010	3400								
	- 1		h	40 10 (01 40	a concoque	1100 017.						6				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	D	ue to (or as	a conseque	nce of):								$\neg$		$\neg$
	.≝	cause. Enter Underlying Cause												- 1		
	Examiner	(Disease or injury that initiated events resulting in death) Last	_	ue to (or as	a conseque	nce of):										
od d ansit			d.									_				
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED		AMENDED												
o, e be e be oburie	G.					fpregnancy						234	Date of de	alivary		$\dashv$
8760, iificate be ng physic	ξ	IF FEMALE: 23b. Was decedent pregnant in	he	1 Live			<sub>2</sub> Fe	tal death 3	Ectopic	pregnan	CV		Month	Da	av Year	
68 certi	<u>.</u>	past 12 months?			nant at time			ner (Specify)		F5	-,				,	
Box 68 he death certi the attendin hed for use as	ış	1 Yes 2 No 9 Ur	known	9 Unkr			3 <u> </u>	ner (Opeciny)								
the d	Physicia	Part II. Other significant cond	tions	contributing	to death bu	t not resultir	ng in the u	inderlying cause of	iven in Pa	irt I.	23e. Did	tobacco us	se contribi	ute to th	ne cause of death?	$\neg$
Records, P.O. I The law requires that the cate has been signed by t	ā	Tank in Other organization				,,,			,		1 □ Y	es 2	No 3 🗸	Proba	ably 4 Unknown	n
ires	둜								_							bla I
beer requ	藚										24a. Wa: auto				opsy findings availat impletion of cause o	
Solution 19 Color Has	Completed				_			-			perf	ormed?		ath?	2 🗆 No	
Re The	Ŝ										1 Yes	2 No	1 1	<b>✓</b> Yes	2 No	_
ian: certif	Be	25. Was case referred to medic examiner?		ospital:					of Death Other			1		1		
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safer death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	.01	1 ✓ Yes 2 No		<sup>35pital.</sup> 1	Inpatient	2 🗸 ER/0	Outpatient		-		Home 5	Residen		Other:		
of ig Pl		27 Manner of Death		28a. Dat	e of Injury th, Day, Year)	28b.	Time of I	njury 28c. Inju	ry at Work	? 2	28d. Describe	how injur	y occurred	t		
ndin ath			nding		(ii, Day, roal)			1	Yes 2	No						
ivisior  I or Attend after death Director: d in by the	ca		estigatio	28e Pla	ice of Injury	- At home.	farm, stre	et, factory, office b	uilding, et	c. 2	28f. Location	(Street an	d Number	or Rur	al Route Number, Ci	ity
Divisior Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification:	det	uld not b ermined	e (Specify		,	,			- 4	or Town,	State)				
Hospital 24 hours Funeral	ပ္ပ	4 Homicide		- 1												
E Fun etely	g	(0)10011 01111	Physicia	ın: To the b	est of my kn	owledge, de	eath occur	rred at the time, di tion, in my opinior	ate and pla	ace, and o	lue to the car	use(s) and	manner a	is starte	d.	
Division of Vital I  To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director.	Medical	one) 2 Medical Ex	amıner:	and manner		ation and/or	rivestiga	tion, in my opinior	i, deali oc	curred at	the time, dat					
F % F 5	Ĕ	29b. Signature and title of certif	ier	2	7 ,,~			29c. Licens	e number			29d D	ate signed	1 (Mont	th, Day, Year)	
		Allersa B	(n 1	1066	14,1	>		O.C.	M.E.			Sept	tember 4	4, 200	)6	
	- 2	Top wind the	er &	ampleto i	10 CC 2	- /ltc== 22 ·									71.0 (12 to	
- C		30. Name and address of personal Melissa Brassell, MD		ompleted ca sistant M				Penn Street, E	3altimor	e. MD 2	21201					
20+									3	-, 2						_
	ate	31. Date filed (Month, Day, Yea	6 20	32.	gistrar's	Signature	h	autil								
Regist	(E)	OEF	A TI	JUUI	JUNEAU.	1 10	147									

State of Maryland / Department of Health and Mental Hygiene 30229 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day SEPTEMBER 12 2006 6:15 PM **Physician** CECIL R. MILLER, SR. /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CECIL RISING SUN CALVERT MANOR HEALTHCARE CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) MAY 2, 15 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X**M 2□F 92 Yrs. 198-05-2714 VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County Canacor, and Mental Hygiene.
Is marked other than "natural", or Items 23e or 28e-f show is marked other than "natural", or Items 20e or 28e-f show raumatic event, it is Medical Exercity at most be notified at 1 Yes 2 No OXFORD CHESTER Director 10g. Cilizen of Whet Country? 10f. Zip Code 10e, Street and Number USA 19363 2125 BALTIMORE PIKE Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PAINTING PAINTER 12 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be BELL RICHARDSON MARTIN MILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5354 HOMEVILLE RD. OXFORD, PA 19363 Department of Health a Important: If item 27 is eny injury or other trau CECIL R. MILLER, JR. / SON 20c. Location - City or Town, Slate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State OXFORD CEMETERY SEPT. 16, 2006 OXFORD, PA 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility EDWARD L. COLLINS FUNERAL HOME, INC 21. Signature of Funeral Service License 86 PINE STREET OXFORD PA L. Collins 19363 dward 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AMOMBAG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EMBAZEMA - END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Physiclen: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No page 2 s 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2☑ No 26. Place of Death (Check only one) funeral director Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienl Other: Nursing Home 5 - Residence 6 - Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Hospitel or Attending J⊠ Natural 5 Pending investigation 2 🗌 No 1 Tyes after death. Director: Af 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) in by 4 [ Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified SPPTEMBER 15, 2006 472B419 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) RISING SUN MD TELRIAPA ROMO Doway, DO Koarin 31. Dale filed (Month, Day, Year) 32. Registrar's Signature State Registrar

I. Decedent's N	ame (First, Middle, Lasi	)							2. Date of Dea			3. Ti	ime of Death
1	Mildred	Elsie		O'Ne:	i1				Septemb			56 8	:30 рм
4a. Facility Name			Cente	er				of Death					
			e (In yrs. Ias 85	t birthday) Yrs.			If Under: Hours	Min.	8. Date of Birth Month Day May 10,	192	9. 8	irthplace (S Country) Vew Yo	State or Foreign Ork
Usual Residence	10b. County		10c. City,	Town or Lo	cation							10d. Ins	ide City Limits
Maryland	Frederic	k	Fred	leric	K							10	]Yes 2≹No
10e. Street and 6861 S		ourt			10f. Zi		21703	3					
3 ☐ Widowe	arried 21 Married	Armed Forces?		'	f Yes, spe	cify Cuba	spanic Origin, Mexican	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		Black, Wh	nite, etc.	ian,
	15. Decedent's Ed	ucation de completed)		(Give	kind of w	ork done d	lurina most	t of workin	g	16b. Kir	d of Busines	s/Industry	
Elementary/S	econdary (0-12)	College (1-4or 5	i+)					k		Pub	lishi:	ng Cor	npany
17. Father's Nan		r Ber	ner									Harre	er
19a. Informant's													
		Removal from State	cen	netery, cren	natory or	other plac			140				
4 Dona	n 5 Other (Specify	)	Cypr				-	_					Y
21. Signature of	Puneral Service Vicens		MOO70										and 2170
shock, or I Immediate Cau disease or cond	neart failure. List only o se (Final lition	ne cause on each lir a Conge	the death. ne. stive	Do not ent	er the mo	de of dying	g, such as					Appro Intervi Onset	oximate al Between t and Death Week
		Due to (or as	a conseque	nce of):									
Sequentially list if any, reading to cause. Enter U Cause (Disease that initiated eve	o immediate nderlying or injury	Due to (or as	а сопавдые	nes of).									•
	n) Last	Due to (or as	a conseque	nce of):									
IF FEMALE:		23c. If yes, outcome	of pregnance	ev						2	3d Date of d	lolivon/	
in the past 1 Yes 9 Unkno	12 months?										Month	Day	Year
A .		_	ut not resulti	ing in the ur	nderlying	cause give	en in Part I.		1				se of death?
	JIIGI TIDII	11401011											
									autops	med?	prior to death?	completion	n of cause of
25. Was case re examiner?		Hospital:				Oth		of Death	(Check only or	) (ө)			
from the same	eath 5 Pending	28a. Date of Inju	ry 2			28c. Injury Work	at	2				ecify)	
2 Accider 3 Suicide	6 ☐ Could not be	200. Flace of Inju	ury - At hom	e, farm, str			res 2∐1				Number or	Rural Route	Number,
29a. Certifier (Check only one)	1X Certifying Phy 2  Medical Exam	iner: On the basis of	examinatio	edge, death n and/or inv	occurred vestigation	at the time n, in my of	ne, date an pinion, dea	d place, ar th occurre	nd due to the c d at the time, d	ause(s) ate and	and manner place, and d	as stated. ue to the ca	tuse(s)
	nd title of certifier				29						-		
						n Dri	ve. F	rede					
	SEP 2 2 2		ar's Signatur				-, -		,	- ) -			
	4a. Facility Name Northal South of 1-14-  Usual Residence 10a. State Maryland 6861 Street and 6861 Street and 1 Good of 1 Market 11 Statu 1 Never M 3 Widowed State 11. Marital Statu 1 Never M 3 Widowed State 11. Marital Statu 1 Never M 3 Widowed State 11. Marital Statu 1 Never M 3 Widowed State 11. Signature of 1 Market 11. Signature of 1 Marital Sequentially list 1 Never M	4a. Facility Name (If not institution, give Northampton Mano  5. \$92 Security Number	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing  5. 99 Security Number	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Center  5. \$99\$Security Number	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Center  5. 609 Security Number 0-11-14-4909   6. Sex 1	48. Facility Name (If not institution, give street and number)  Northampton Manor Nursing Center  5. 690 Security Number 691-14-4909  1	As. Facility Name (If not institution, give street and number)	A. Facility Name (If not institution, give street and number) Northampton Manor Nursing Center Frederick  S. 99 Security Number Off-14-4909  10 M 2D F 7. Age (In yrs. last birthday) Morths Days   Hours   House   Hours   Waryland   100 County   Frederick   100 City   Town or Location   Frederick   100 County   100 Elegan   100 County   Frederick   100 Elegan   100 County   Frederick   100 Elegan   100 County   Frederick   100 Elegan   100 Elega	4a. Facility Name (if not institution, give street and number)   Northampton Manor Nursing Center   Septimbry Nursing Nursing   Septimbry Nursing Nursing   Septimbry Nursing Nursin	46. CBy, Town or Location of Death  Northampton Manor Nursing Center  Frederick  10	46. Februik Name (If not instruction of Name Single Center   16. Sex   16. S	to February Northampton Manor Nursing Center    Secondary February Nurses   County Operation   County   County Operation   County   County Operation   County   Count	Security New of Year partitions; give arrest and manufact   Security New Orthampton Manor Nursing Center   Security New Orthampton Manor Nursing Center   Security Nursing C

			1 - State of Maryla Registrar	•	artment of He rtificate of D	eath	Reg.	2006	30231
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Wendy LYNN		Pinkne	<i>t</i> !	2. Date of Death Month September		3. Time of Death 4:30 AM
	Examir Funeral Director	er	4a. Facility Name* (If not institution, give street and number)  The Johns Hopkins Hospita  5. Social Security Number  175–56–1968  6. Sex  7. Age (In y)  1 M 24 F  44	rrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 2, 196		lace (State or Foreign try) lvania
	a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County 10c.  Virginia Prince William	City, Town or Lo			Jella Lag IV		0d. Inside City Limits 1 ☐ Yes 2 🏹 No
	th with the 23a or 28	ai Director	10e. Street and Number  14335 Westminister Lane #	<u>1</u> 11	10f. Zip Code 22193			Citizen of Whal Coun	try?
980	72 hours atter death with the Maryland natural', or teme 23a or 28a-1 ehow dittal Examiner must be notilled at	by Funeral	11. Marital Slatus  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Never Married 2 Married If Yes, Give Year or Dates:	i	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Spec Mexican, Puerto F Specify:	orly Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0036	within ane. then "	Completed	15. Decedenl's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4	(Give	dent's Usual Occupati b kind of work done du DO NOT use retired) DO1 Teach	ring most of workin	9	. Willia	
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) William Stanley McCarthy		I		Ann Ho	ckenbroc	
Baltimore, Mar	permit. Pages 1 and 2 should Dep riment of Health and Mer Important: if item 27 le marke any injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationship (Type, Print)  Reda W. Pinkney, II  20a. Method of Disposition 1 ◯ Burial 2 ◯ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature, Funeral Service Licensee	14335 b. Place of Dispo cemetery, crea Resurre	5 Westmir  osition (Name of matory or other place) ection Ce	nister I	a. #11 ate 200 2/06 C]	ity or Town, State, Zip Woodbrid 5. Location - City or To Linton, Md alas Fune	lge, VA. 221 own, State
Ba Ba	Department of the partment of		23a. Part Enter the disease or complications that caused the caused the caused the caused the cause on each line.	6	160 Oxon	Hill Ro	d. Oxon	Hill, Md	Approximate Interval Belween
38760,	Physician / Medicale pe executed by Medical Examiner as the prival-transit as the prival-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Eaguentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the cause of the cause).  Due to (or as a condition of the cause).  Due to (or as a condition of the cause).	utic s uence of):	1 failur anemi incir	a			Onset and Death  12 hours  4 days  2 years
P.O. Box	at the death certil by the attending tached for use a	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, oulcome of prediction in the past 12 months?  4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year
ords, P.	w requires that been signed by should be deta	ρ	Part II. Other significant conditions contributing to death bul not	resulling in the u	underlying cause given	in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the	ne cause of death? ably 4 Unknown
of Vital Records,	ysician: The law r is certificate hes bu director, page 2 sh	e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed 1 Yes 2 -	prior to cor death?	psy findings available npletion of cause of 2 No
Division of Vi	Attending Ph sr death. ector: Atter th by the tuneral	Certification; To B	examiner?	Al home, farm, st	of 28c. Injury a Work?	4 Nursing Homat 2 ss 2 No	ne 5 Residenc 8d. Describe how	t and Number or Rura	,
٦	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely tilled in by the	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examand manner stated.	nination and/or in	nvestigation, in my opin	nion, death occurre	d at the time, date	and place, and due to	the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier week we		29c. License	0203	29d. <b>Se</b> t	Date signed (Month, I	Day, Year)
R	Sta Regist	ate rar	30. Name and address of birson who completed ause of death Rosalyn Juergens no 1150 de 31. Date filed (Month, Day, Year) SEP 1 1 2006	Item 23a) (Type, or leans	Street John	ns Hopkin	s CRB-1	Blo Baltin	2006 21231 MARC, MARY

		-	For State Registrar		State of	Marylar		artmen <i>rtificati</i>					Reg. No.	20	106	30232
	Physici		Decedent's Name (F)	irst, Middle, La	ist)		2211					2. Date of Dea	Day	,	Year	3. Time of Death
	/Medic	al	JOSEPH 4a. Facility Name (If not	t institution aiv	e street and num	ber)	PRUIT	T	Town, or	Location of	of Death	SEPTEMI			of Death	3:35P M
	Examin	er	6809 ELDRI			/		1		ER H				PRI	NCE G	EORGES
	Funeral		5. Social Security Numb	per 6. 5	Sex 7	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)		9. Birthpla Countr	ace (State or Foreign
	Director		579-58-665		XXM 2□F	60	Yrs.					08/20/1				NGTON, DC
	fand ow			b. County		10c. Ci	ty, Town or Lo	ocation							10	d. Inside City Limits
	Mary B-f sh	ţċ	MD E	PRINCE	GEORGE'S	LAN	DOVER	HILLS								XXYes 2 □ No
	or 28	Director	10e. Street and Number	r				10f. Zip	Code				10g. Citize	n of V	What Count	y?
	s 23e	ral	6809 ELDRI	DGE ST		test Fires in I	1.5	207		inneria Ori	ining (Co.	acity Voc or No	USA	1 Pac	e - America	n Indian
920	be filed within 72 hours after death with the Maryland tal Hyglene dother than "natural", or items 23e or 28e-f show event, the Medical Examinational templied at	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>3 ☐ Widowed 4 ☐</li></ul>	2 X X arried	12. Was Deced Armed Ford 1 TYes 2 If Yes, Give Year or Da	ces?		Was Deced If Yes, spec 1 ☐ Yes	cify Cuba	ispanic Ori in, Mexicar Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Blac	ck, White, e	ic.
21215-0036	72 ho natur	Completed		Decedent's E	ducation ade completed)		(Give	dent's Usua kind of wo	rk done d	during mos	t of worki	ng	16b. Kind	d of Bu	usiness/Indu	ıstry
2	within lene. than "	mple	Elementary/Seconda		College (1-	4or 5+)	JOURN	DO NOT us	se retired	()			SHOP	PER	S FOO	D
2	filed v Hygie other t		12 TH 17. Father's Name (Firs	st, Middle, Last	!)		000111					(First, Middle,				
an		To Be	CHESTER PR							JOSEF	PHTNF	YOUNGE	ER			
Maryland	S S E E	<b> -</b>	19a. Informant's Name		(Type, Print)		19b. Maili	ng Address	(Street a			I Route Numbe		Гошп,	State, Zip (	Code)
	1 and 2 Health a Iem 27 is		EULA PRUITI	C/WIFE						ST. I		VER HII				
Baltimore,	0 0		20a. Method of Disposit		☐Removal from S		Place of Dispo cemetery, cre RMONY	matory or o	ther plac	(8)		2/2006			City or Tow	m, State
ţ	permit. Pag Department Important: any injury c		°4 □Donation 5 □			I IIA				l La						
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funera	raP.	-Pner	sho	W.	4308	SUI	TLAN	D ROA		ITLAN	ARY D,	MD 20	746
	Pnysician		Immediate Cause (Findisease or condition	ilure. List only	one cause on ea	ch line.	AC ARR			g, such as	cardiac d	or respiratory ai	rest,			Approximate interval Between Onset and Death
	/Medical Examiner		resulting in death)	(		or as a conse										
		i.	Sequentially list conditi	ions,	b.	O MYOP or as a conse										
	uted d ansit	Examiner	cause. Enter Underlyin Cause (Disease or inju- that initiated events	10			HYPER	TENSI	ON							
ó	an and rial-tra	Exa	resulting in death) Last	١ ا	Due to (d	or as a conse	quence of):									
8760,	icate be executed physician and s the burial-transit	lcal		•	d. OBESI	TY										
.O. Box 6	The law requires that the death certiticate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mo 1  Yes 2 Ne 9 Unknown	nths?		th 2 ☐ Fet int at time of	aldeath 3(	⊒Ectopic pi ⊒ Other (sp					23	3d. Dat Mo	te of deliver onth C	y Day Year
٥,	es that igned b	by Pł	Part II. Dther significan	nt conditions	contributing to de	ath but not re	sulting in the u	underlying o	ause giv	en in Part I	l.	23e. Did to	obacco us	a conti	ribute to the	cause of death?
ecords,	w require been sig should t		CONGESTIVE	E HEART	' FAILURE							10	res 2□	No	3 Proba	biy 4X☐Unknown
ecc	e taw r has be	Completed										24a. Was autor	osy	F	prior to com	sy findings available pletion of cause of
E B		Con										1 Yes	med? 2 <b>XX</b> Vo		death?	P No
Vital	Physician: The ration of this certificate ral director, page	Be	25. Was case referred examiner?	to medical	Hospital:		75000		Oth			n <i>(Check only c</i> me <b>XX</b> Resid			/0/	
of	Phys or this oral dii	υ: Το	1XXes 2 No 27. Manner of Death	- Aminos	28a. Date o	f Injury	28b. Time of		28c. Injun Worl	4 🗆 140		28d. Describe				
ion	Attending F r death. ector: Atter by the tuner	atlo	XX Natural 5	Pending investigation		n, Day Year)	Injury	М		K? Yəs 2□	No					
Division	or Attendent after death Director: d in by the	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	G Could not I determined	286. Place	of Injury - At t g, etc. <i>(Spec</i>	nome, farm, st	reet, factor	y, office			28f. Location (3 City or Tox	Street and vn, State)	Numb	er or Rural	Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely tilled in by the	Medical C	29a. Certifier XX (Check only 2 one)	Certifying P	hysicien: To the iminer: On the ba and many	sis of examin	owledge, dea ation and/or ir	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) a date and p	nd ma	anner as sta and due to t	ted. the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title	e of cerutier	h	H	7	29		e number	27		29d. Date	signer	d (Month, D	ay, Year)
),	(0		• (	the	Mary 1	eur			A	218	7		71	7/	100	,
1	(10)		30. Name and a ss HEMA P. Y.		1D 9470 A	ANNAPO1	LIS RD.	. #315	5 LAN	NHAM,	MD 2	20706				
	Sta Regist	ate rar	31. Date filed (Month, 1	Day, Year) 1 2006	32. Re	gistrar's Sign	Chee	W								

			1 - For State Registrar	State of Maryla	and / Depa	artment of rtificate of	Health and Death	Mental Hyg	iene2006	30233
	Physici /Media	cal	Decedent's Name (First, Middle, Last)     Thelma Parsons					2. Date of Death Month Sep.	6, 200	6 3:05 a M
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give s  340 Sheffield Roc  5. Social Security Number  550-54-3050  Usual Residence of Decedent	ad	rs. last birthday) Yrs.			k 8. Date of Birth	9. 8i	alh  Arundel  thplace (State or Foreign country)  ited Kingdom
	Maryland f show	tor	10a. State 10b. County MD Anne An		City, Town or Lo		erna Park	ζ		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	a or 28a	Funeral Director	10e. Street and Number  340 Sheffield Road	 d		10f. Zip Code	21146	10	g. Citizen of What C	•
036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funera	11. Marital Status  1 □ Never Married 2★ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	within 72 ho one. ihen "natur ie Medical J	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	DO NOT use retir	e during most of wo ed)	orking	6b. Kind of Busines	
Maryland 2	uld be filed v Aental Hygie rked other t tlc event, to	To Be Co	12 17. Father's Name (First, Middle, Last) Arthur Browne			Homema	1	me (First, Middle, M ler	HO faiden Sumame)	me
e, Mary	l and 2 shoule and North a		19a. Informant's Name/Relationship (Ty) Roy Parsons/Husbar	nd	340	Sheffie		Severna F	<u> </u>	21146
Baltimore,	nit. Peges that the parament of Horizontant: If the injury or other		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21 S nature of Foneral length answer.	lemoval from State	cemetery, crer letro Cr	esition (Name of matory or other placematory)  Cematory  2. Name and Addr	Sep	. 7, 2006	Baltimore	
Ba	Depa Timpo Timpo Ony it	4	23a. Part1. Enler the disease, or compliant shock, of heart failure. List only on	Sections that caused the de	B: 4	arranco 95 Gov.	& Sons, F Ritchie F	Iwy, Sever	na Park,	uneral Home MD 21146  Approximate Interval Between
	Physician /Medical Examiner		mmediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		lavial	1 Cau	cev		Onset and Death
,160,	rate be executed hysicien and the burial-transit.	Ical Examiner	Sequentially list conditions, Aany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
.O. Box 68	The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. II yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	olivery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	itributing to death but not re	esulting in the u	nderlying cause g	ven in Part I.			o the cause of death?
al Records,		Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of s 2 No
<b>=</b>	ysicien: Th s certificete director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	nt 3 DOA Ot	hor	ath (Check only one	) nce 6 □Other (Spe	noihi)
Division of Vital	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date ol Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe how		wiy)
DIVIS	2 ± ± €	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or Town,		
	To the Hospitel within 24 hours a To the Funeral C completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occi	e, and due to the cau urred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
)	To the Vithin 2 To the complete	Me	29b. Signature and title of certifier	ruil, wo	)	29c. Licen	se number 19838	> 29	d. Date signed (Mon	th, Day, Year)
	12			mpleted cause of death (Ite	em 23a) (Type,	Print)	Bestga	te Ra	Annap	olis, Md,
	Sta Registr		31. Date liled (Month, Day, Year) SEP 0 7 2	32. Registrar's Sign	nature	hade o				

		1 - For State Registrar	State of N	Naryland / De C	partment of Health ertificate of Deat	and Mental Hy h	ygiene2006	30231
Physic /Med		1. Decedent's Name (First, Midd Tashawa	Ere	mene	Parke-	2. Date of D Month	Day Year	3. Time of Death  Y61 A M
Exami Funera Director		4a. Facility Name (If not institution  Mary I and  5. Social Security Number  218-92-9288	Shack .	T ( A v M 4 Age (In yrs. last birthda 27 Yrs.	Months Days Hours	er 24 Hrs. 8. Date of Bi	irth (24, 1979) 4c. County of Deal	thplace (State or Foreign ountry) <b>Maryland</b>
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. Count  MD Prin	ce George's	10c. City, Town or		urel		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
h with the 23a or 28i	al Director	10e. Street and Number 11398 Laurel Walk D	rive		10f. Zip Code	708	10g. Citizen of What Co	*
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygione. itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant, Its Medical Examinations is	by Funeral	11. Marital Status  1X Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	No No	3. Was Decedent of Hispanic ( If Yes, specify Cuban, Mexic  1  Yes 2 No Specif		o- 14. Race - Ame Black, Whit Specify: Bla	e, etc.
filed within 72 ho Hygiene. other than "natur ant, Ite Wad Gal	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12) 11	nt's Education st grade completed)  College (1-40	(G.	cedent's Usual Occupation ve kind of work done during m b. DO NOT use retired) Child Care Pro		16b. Kind of Business/	•
should be filed and Mental Hygis marked other	o Be C	17. Father's Name (First, Middle	Tyrone Jo	nes	18. Mot	her's Name <i>(First, Middle</i> D	e, Maiden Sumame) arlene Parker	
and 2 should ealth and Men n 27 Is marke		19a. Informant's Name/Relation Darlene Parker/mot		1	illing Address (Street and Num 198 Laurel Walk Drive			Zip Code)
Page nent c ant: If ary or		20a. Method of Disposition 1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		te cemetery, c	position (Name of rematory or other place)  Vestern Cemetery	Date 09/01/06	20c. Location - City or Prince Fre	
permit. Departr Imports any inji		21. Signature of Funeral Services	7. Sewell	0	22. Name and Address of Fac Sewell Funeral 1451 Dares Be		Frederick, MD 20	0678
cate be executed when the private in	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate auto Et al. Octyring Cause (Disease or injury that initiated events resulting in death) Last	b	as a consequence of): as a consequence of):	IIICS	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M. Janether	
the death certifi y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 ⊟Ectopic pregnancy 5 □ Other (specify)	C. R. Hice J.	23d. Date of del Month	ivery Day Year
es lgn	by	Part II. Other significant condit	ons contributing to death	but not resulting in the	underlying cause given in Par		tobacco use contribute to Yes 2 X No 3 ☐ Pr	the cause of death?
The law ate has b page 2 s	Completed					24a. Was auto perfi 1 □ Yes	opsy prior to o ormed2 death?	topsy findings available completion of cause of
l or Attanding Physician: Thater death. Diractor: After this certificate	Certification; To Be	25. Was case referred to medici examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide	Hospital: 1 Linpa 28a. Date of Ir (Month, Linpa 3 2 2 200 28e. Place of I	njury 28b. Time Da <i>y Year)</i> Injur	ient 3 DOA Other: 4 1 of y Work? 1 Yes 2	28d. Describe  CAR WH  28f. Location ( City or To	orfe)  idence 6 □Other (Special National National Number or Ruck (Street and Number or Ruck (Street a	FIXED OBJECT OF A POUT OF NUMBER,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the bes	of examination and/or	eath occurred at the time, date investigation, in my opinion, d	and place, and due to the	cause(s) and manner as	stated.
To the I within 2 To tha Complet	Me	29b. Signature and title of certific	- Chil	,	29c. License numbe	r	29d. Date signed (Month  08/28/0	•
Si Regis	ate	30. Name and address of persor Steven Chmil, M.I.  31. Date filed (Month, Day, Year AUG 3 1 2)	). 22 S. Greene S		, MD 21201			

		1- For Amend Item 21 State of Maryland Department of Personal Pers	lealth and Men Death	ntal Hygiene Reg. No.	2006	3023
Phys		Decedent's Name (First, Middle, Last)     MARY ELIZABETH RANDALL		Date of Death Month Day PRIL 15	, 2006	3. Time of Death 6:03A <sup>M</sup>
1	dical niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, of Anne Arundal Medical Center  Annapol	or Location of Death	4c. (	County of Death	
Funer Directe		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year Months Days	Hours Min. (	Date of Birth (Month, Day, Year)	Countr	ace (State or Foreign ry) W York
Maryland -f show	lo	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Annapolis			100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the 23e or 28e at be notifi	ai Director	10e. Street and Number 10f. Zip Code 2104 Chesapeake Harbour Dr. East 21	1403		zen of What Countr	y?
Baitimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Sive 1 Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 2 No	Hispanic Origin? (Specify an, Mexican, Puerto Rica Specify:		14. Race - Americal Black, White, et Specify: Whi	tc.
Maryland 21215-0036 nd 2 should be filed within 72 hours alt lith and Mental Hyglene. 27 le markad other than "naturel", or rtraumatic event, the Madical Exerci-	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  1 2  16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire  Owner - Ope	during most of working ed)		nd of Business/Indu	ıstry
VIZING A buld be filed Mental Hyg arkad other attic event,	To Be C	17. Father's Name (First, Middle, Last) Wallace L. Randall	18. Mother's Name (Fin	rst, Middle, Maiden		
y Mar and 2 sh salth and n 27 le m		19a. Informant's Name/Relationship (Type, Print)  Sara R. Mullin (sister)  19b. Mailing Address (Street 224 Tockwo				
SAITIMOTE, Dermit. Pages 1 ar Department of Hea mportent: If item iny injury or othe		20a. Method of Disposition  1	1   4/22/		cation - City or Tow yrna, DI	
Dermii Depar Impor	Suce	21. Signature of Funeral Service Licensee  Stephen L. Schaech per DVR  22. Name and Address Galena I 18 West  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	Funeral Ho Cross St	ome of St	tephen I	L. Schaed
/Medica /Medica Examine	al	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a				Interval Between Onset and Death
.U. DOX DO/OU, the death certificate be executed y the ettending physicien and tched for use as the burial-transit	Physician/Medical Exa	resulting in death) Last Due to (or as a consequence of):	у	2	3d. Date of delivery	y Day Year
that the sed by detac	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.	23e. Did tobacco us	se contribute to the	
al Kecord  1: The law requir  cate has been s  r, page 2 should	Completed			24a. Was an autopsy performed? 1 Yes 2 □ No	prior to come death?	sy findings available pletion of cause of
INVISION OF VICAL RECORDS, I or Attending Physician: The law requires I effer death.  Director, there this certificate has been signs in by the funeral director, page 2 should be.	atlon: To Be	27. Manner of Death 128. Date of Injury 28b. Time of Injury Worth, Day Year) 28c. Injury Worth 15€Natural 5 Pending (Month, Day Year) 15€Natural 25 Pending 15€Natural 15€Natur	26. Place of Death (Chair)  A Nursing Home  ry at rk?  Yes 2 No			
UNISIO tal or Attendir s efter death. el Director: A	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (Street and City or Town, State)		Route Number,
To the Hospital or At within 24 hours effer or To the Funerel Direct completely filled in by	Medical		opinion, death occurred a	t the time, date and	place, and due to t	the cause(s)
To T To t	Σ		19838 25tgate R	29d. Date	signed (Month, De	ву, Year)
		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  + UOV+ E	astgate R	ed. Au	napolis,	Mil.
	State strar	SEP 1 8 2006  SEP 1 8 2006  SEP 1 8 2006				

DHMH 17 Rev 1/2001

Registrar

SEP 1 2 2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Cruz Antonio Raye	1	- For State	ate o	f Maryla		•		Health Death	and	Menta	ıl Hyg		a. Na		
Physician	1/	t <b>egistrar</b> 1. Decedent's Name (First, Midd	e,Last)					D G G G				Date of Deat		20 Year	35 me of Death 2
Medical Examine		Cruz			A.	Re	eyes					Month Septembe			0735 hrs
()	ı	<ol> <li>Facility Name (if not institution</li> <li>2004 Wolf Street</li> </ol>	n, give s	street and nu	mber)		'	b. City, Town			Jeath			ounty of Dea ICe Georg	
Funeral	7	5. Social Security Number	6. Sex		7. Age (In	yrs. last b	oirthday)	If Under 1	Year	If Under 2	24Hrs.	3. Date of Bir	th(MM/DD/	YYYY) 9. B	irthplace (State or
Director	1	Unk.	XX,	/ 2 F	23		Yrs		Days	Hours	Min.	May 18	1983	C	ountil Salvado
aux	ŀ	Usual Residence of Decedent  10a. State 10b. County			1100	City Toy	vn or Locati	on							10d. Inside City Limits
d d	_		ce V	Villia			dbrid								1 X Yes 2 No
arylan 8a-f s	Director	10e. Street and Number		-				10f. Zip Co				1	0g. Citizen	of What Co	untry?
3a or 3		12797 Cara D	r.					22	192				EL Sa	lvado	r
ath witl	Funeral	11. Marital Status  1 X Never Married 2 M	arried	12. Was Dec Armed Fo	orces?			s Decedent o es, specify C					- 14.	Race - Ame White, etc.	erican Indian, Black,
fter de fter de fter de fter de	- 1		orced I	1 Yes f Yes, Give Yea	2 X	No	1X	Yes 2	No s	specify: S	Salva	adoria	n sp	<sub>ecify:</sub> Wh	ite
ours a	g S	15. Decedent's Education (Spe		or Dates: / highest grad	de comple	ted) 16		t's Usual Occost of working					16b. Kind	of Business	s/Industry
36 in 72 h han "r		Elementary/Secondary (0-12)		College (1	-4 or 5+)		_	tructi		01101 0	70 101100	,	Ruiz	z Cons	truction Co.
5-0036 lied within 7 Hygiene. t other than	Completed	17. Father's Name (First, Middle	, Last)						18.			irst, Middle,		rname)	<u> </u>
21215 ould be file Mental H marked ic event, t	å	Cruz Reyes								Reyna			.az		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinal must be notified at once.	2	19a. Informant's Name/Relations Blas A. Diaz	hip (Typ	ther)				Address (S Tenbr			er or Run Mai	al Route Nur Nassas	nber, City o	or Town, Sta <b>rginia</b>	te, Zip Code) 20155
Te, N 1 and 1 Health Fitem 2		20a. Method of Disposition	• [	7	-	20b. Plac	e of Dispos natory or otl	ition (Name o	of ceme	tery,		Date	L20c. Loc Santa	ation - City o	ta Cemetery
Pages Pages nent of ant: It		Burial 2 Cremation 4 Donation 5 Other S		Removal fr	om State	Sant	a Cla	rita C	eme	tery			La Ur	nion,	El Salvador
Baltimore, permit. Pages 1 ar Department of He Important: If ite	1	21. Sign e of Funeral Service		Sec. 1	2		22. N	lame and Add 9013 <i>P</i>	dress of	Facility	Re: Rd:	n on T Lamb	ale I	mera	1 none
Physician	1	237. Part I. Enter the disease, o	c i plic	cations that c	aused the	death. Do									Approximate Interval
/Medical Examiner	4	failure. List only one cause Immediate Cause (Final disease		h line. Acute a	lcoho.	l into	xicatio	on							Between Onset and Death
Examine:		or condition resulting in death)		ue to (or as a	conseque	ence of):									
	힐	Sequentially list conditions, if any, leading to immediate		ue to (or as a	conseque	ence of):									1
	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	ue to (or as a	conseque	ence of):									
		events resulting in deathy Last	d				MILL OF	0.10/6	/02 [						
e be exe	edical	X UNPENDED	X	AMENDED	item	#1,per #23a.2	тш, gec 7, 28a-	0, 10/6. f.perÆ.	/Ub . .2859	11 0,9/28	/06 T	T			
6876 certificate nding phy	Ž	IF FEMALE: 23b. Was decedent pregnant in t	he	23c. If yes, 1 Live b		of pregnan		tal death	3	Ectopic p	regnanc	у		ate of delive onth	ery Day Year
Box 6 e death cer the attendied for use a	Physician/M	past 12 months?  1 Yes 2 No 9 Un	known			e of death		her (Specify)							
by the by the fiched fi		Part II. Other significant condi		9 Unkn		it not resul	ting in the t	ınderlying ca	use give	en in Part	I.	23e. Did te	obacco use	contribute t	to the cause of death?
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy uneral director, page 2 should be detached for use as the land of the standard of the detached for use as the land of the detached for use as the land of the detached for use as the land of the detached for use as the land of the detached for use as the land of the detached for use as the land of t	<u>چ</u>							, -	_			1 Ye	s 2 N	lo 3 Pr	obably 4 🗸 Unknown
ords v requi	Completed											24a, Was			autopsy findings available completion of cause of
Reco	틹				·	·				•			rmed?	death?	
tal F	Be Be	25. Was case referred to medica examiner?	_					26.		Death (C	heck onl				
of Vital Records, ng Physician: The law requir offer this certificate has been s meral director, page 2 should t	₽	1 Yes 2 No 27. Manner of Death	HO		of Injury		Outpatient  b. Time of I			her: at Work?		Home 5 3		e 6 ✓ Oth	er: Scene
on on on on the func	اق	1 Natural 5 Pen	ding	28a. Date (Month	, Day,Year) 9/16/20		nd 7:3			2 <b>y</b> N	.	unk	, ion injury	33341703	
Division tal or Attendin rs after death. al Director: A led in by the fu	Certification	. 🗆 🖅	stigation	28e Plac	<u> </u>			et, factory, of	_	- 41			Street and	Number or F	Rural Route Number, City Street
Spital nours a neral I filled	5	4 Homicide dete	rmined	(Specify)	Ho	use					F	ort Was	hingto	n, MD	- Direct
0 5	Medical	29a. Certifier 1 Certifying F (Check only 1 ✓ Medical Exa	miner:	n the basis	of examina			red at the tim tion, in my op							
To To con	ĕŀ	29b. Signature and title of certifi	ē	and manner s	tated.				cense r			· .			Ionth, Day, Year)
		Jane Lo Rush	10/1	MA				C	C.M.	E.			Septer	mber 17,	2006
(X= (3)	1	30. Name an spreas of person						) Ot:	D	Man e	MDG	1204			
Sta	ta	Pamela Southall, MD		sistant Me	dical Exegistrar's		111 F	Penn Stree	et, Bal	umore,	IVID 2	1201		· -	
Registr	ar	SEP 1 9 2006	B	Bur	K	400	W.								

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 **Physician** AUDREY B. REDISH 4:34 P.M. 2006 05 /Medical 4b. City, Town, or Locetion of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BOWIE HEALTH CARE CENTER BOWIE PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 1 - 22 - 1936 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□ M 2√XF Months 578-48-6972 69 Yrs. VIŘĞÎŃIA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mantal Hygiene. Instruel, or theme 23a or 25a-f show int: If Item 27 is marked other than "natural, or theme 23a or 25a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at XXYes 2 □ No Funeral Director MDPRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15609 EVERGLADE LANE #102 20716 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ☐Yes 2☐No Yes, GiveXX altimore, Maryland 21215-0020 1 ☐ Yes ŽŽNo Specify: BLACK Be Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PAYROLL SPECIALIST HHS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE WASHINGTON BERRY GLADYS GREGORY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARLEN M. ANDERSON/DAUGHTER 37 TUCKERMAN ST. NW WASHINGTON, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 9/11/06LANDOVER 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 21. Signature of Funeral Service Licensee 4308 SUITLAND RD., SUITLAND, MD 20746 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Atheroscherotic Cardioviscular Heart Disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown þ 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 2010 1 J Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this c 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: A filled in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D completely filled i 29a. Certifier (Check only one) edicai 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 1 2006 Registrar

			1 - For Stata Registrar Amend #26	State of Marylar	-				giene Reg. No. 2006	30239
		157 g	Decedent's Name (First, Middle, La		00 200	amouto or	Dodin Gi	2. Date of Dea	ith	3. Time of Death
	Physici		Thomas T. Ra	ymond				Month	Day Year 2006	11:29 P M
γ.	/Medic Examir		4a. Fecility Name (If not institution, giv	*		4b. City, Town, o	or Location of Dea		4c. County of Dear	
H	LAGITIII	ICI	Kline Hospice Hou			Mt. Ai			Freder	
7	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	n 9 Bir	thplace (State or Foreign
П	Director		578-52-4770	¹XIM 2□F 66	Yrs.	Months Days	Hours Min	June 13		ountry) shington D.(
	D .		Usual Residence of Decedent	10-0						
	anyla shov	<u>-</u>	10a. State 10b. County	10c. Cr	ty, Town or Lo	ocation				10d. Inside City Limits 1X Yes 2 □ No
	Ba-f	Director	Maryland Frederi	Lck	Fre	derick				
	with t		10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	-
	a 23c	Funeral	1743 Algonquin Ro	12. Was Decedent Ever in U	C 12		701	2	United S	
	Itam Itam	n n	11. Marital Status 1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No	.5. 13.	If Yes, specify Cub	an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
38	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ane. then "natural; or Itama 23a or 28a-f show the Madical Exemited must be inclified at	ted	15. Decedent's E	ducation	16a Dece	dent's Usual Occup	pation		16b. Kind of Business	Industry
75	7 Un U	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) Coilege (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	orking		,
2	d with	mo:	Liementally/3600ndary (0-12)	+4	Sale	s Repres	entative		Marine Ai	r Supply
	be filed vital Hygie of other tevent. In	Bec	17. Father's Name (First, Middle, Last,	)			18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>ā</u>	Aents Aents rked	ToE	William T. Ray	mond			Lucie	Heard		
Maryland	as 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. I flem 27 is marked other than "natural", or Itama 23a or 28a-1 show other traumatic event. The Medical Exercities Gaust be notified as		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number	r, City or Town, State, 2	Zip Code)
	and 2 lealth m 27 in		Mary Anne / Wife	:	1743	Algonqui	n Rd., F	rederick,	, MD 21701	
altimore,	ges 1 it of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		Place of Disponentery, crea	osition (Name of matory or other plan	ce)	Date	20c. Location - City or	Town, State
Ĕ	Pages nent of l ant: If its ary or o		4 □ Donation 5 □ Other (Specif	Tranioval noin State		Cremato	1	/2006	Frederick,	Maryland
a	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licer	nsee	2:	2. Name and Addre	ss of Facility St	auffer Fu	ineral Home	
<b>a</b>	8 5 E 5 8	i iu	1 outher	Staukler		1621 0	possumto	wn Pike,	Frederick,	MD 21702
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the deat	h. Do not en	er the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
ę.	Physician		Immediate Cause (Final disease or condition	Mak-				,		Onset and Death
Fr	/Medical		resulting in death)	a. Due to (or as a conseq	uence of):	FV05+2	ne ca	range		18 month?
	Examiner		Convention list conditions	b						
	T =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):					
	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events	c						
Ö,	e exe ian a urial-	Ä	resulting in death) Last	Due to (or as a conseq	uence of):					
8760	cate be executed physician and the burial-transit	dical		_ d						
9		Med	IF FEMALE;							
ROX	death certifi e attending I id for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta	I death 3[	Ectopic pregnancy	/		23d. Date of deli	•
o O	0 00	Sic	1 Yes 2 No	4☐ Pregnant at time of d 9☐ Unknown	eath 5	Other (specify)			Month	Day Year
٦.	The law requires that the to has been signed by the bage 2 should be detache	Phy								
ŝ	res th	þ	Part II. Dther significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to	
20	w requir been si should I	ted						1 🗆 Ye	es 2 No 3 □ Pr	obably 4 Unknown
Hecords,	e law has b	ple						24a. Was a autops		topsy findings available completion of cause of
=	10	Completed						perforr	med? death?	2 No
VITal	cian: ertific actor,	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on	18)	
0	> 0 0	၉	1 ☐ Yes 2 X No		ER/Outpatier	t 3 DOA Oth	er: 4 Nursing I	teme 5 Reside	ence 6X Other (Spec	cify) Hospice
Ē	ding Ph h. After th funeral	6	27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k?	28d. Describe ho	ow injury occurred	House
DIVISION	tend leath tor: / the fi	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
₹	or At fter o lirect in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
_	urs a urs a urs t urs!									
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After cumpletely filled in by the funer	edical	29a. Certifier Sertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina	wledge, deat ition and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the in- urred at the time, d	aus (s) and marrier as ate and place, and due	to the cause(s)
	the the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens				
	5 4 K	=11	\$ \$\tag{1} \tag{1} \tag{1} \tag{1} \tag{1}	Sm) eller !		10 Of	73000	0	9d. Date signed (Monti	i, Day, Year)
7	6		Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	with appropriate	J hand	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			01/07/	2006
			30. Name and address of person who	completed cause of death (Item	n 23a) (Type, ₁Λ		11.03	1. 592	1 1-	7
			31. Date filed (Month, Day, Year)	32. R _ tr ''s Signa	Dex	ell, We	il Cost	ile inc	V-1+4	2
	Sta Registr	F = .00	SEP 0 8		L	1				
	2014114	- 1	SEPUB	7000 C	N. A	Delle .				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygieney 30240 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) September 6 **Physician** 2006 3:45P William Edwin Riddle, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 528 Daisy Drive Carroll Taneytown ff Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 14, Year) 954 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1(XM 2□ F 7. Age (In yrs. last birthday) **Funeral** Months Mary land 51 Yrs 216-68-3546 Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location worle in then "natural", or items 23a or 28a-f ehoving Medical Examinar must be notified at 1XYes 2 No Maryland Carroll Taneytown Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with 21787 U.S.A. 528 Daisy Drive Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Item eny injury or other traumatic event, the Medical Examinar page. Bfack, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) stair components 10 carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thelma Schapper Joseph H. Riddle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 Daisy Dr. Wanda Riddle/ wife Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Evergreen Mem. Gardens 9/11/2006 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Filneral Service Licensee 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine ed by the ettending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of defivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ certificate has been significator, page 2 should be OBESITY MORBID 1 Yes 2 No 3 Probably 4 donknown Completed COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DM 2□ No 1□ Yes 2 No 1 Yes the Hospitel or Attending Physician: nin 24 hours effer death. the Funerel Director; After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel c within 24 hours of To the Funerel D completely filled in 29a. Certifier 1 Certitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0054580 M.D. WSL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE FAKHAR, M.D. 417 E 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 1 2006

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

_			1 - For State Registrar	State of Marylan	a / Depa <i>Cer</i>	triment of H	leaith and i D <i>eath</i>		giene Reg. No.	2006	30241
	¥ 1		Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	V	3. Time of Death
	Physicia /Medic		BESSIE ELIZABETH	STEVENS				9-3-2	.006	Year	1:42 P M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deat	h	4c. (	County of Death	1
				B1vd ex 7. Age (In yrs. I	last high day)	Oxon Hi	L1 If Under 24 Hrs	8 Date of Bit		ince Ge	
	Funeral Director			DM 20XF 89	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Date 4-8-19	17. Year)		nplace (State or Foreign untry) eper VA
	yland 10W		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow rests be notified at	ctor	MD Prince Go	eorge's 0	xon Hi	11					1y∑Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	untry?
	ath w	ral	5009 Woodland Bl			20745				ted Sta	
		Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	specify Yes or No to Rican, etc.)	)·   1	<ol> <li>Race - Amer Black, White</li> </ol>	
36	ours after death with the Marylar rel', or Hems 23a or 28a-1 ehow Examinar natel be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1	1	I□Yes 2₺ No	Specify:			Specify: Bla	ck
ğ	72 hours "natural", ulcal Exp	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occup	ation	duna	16b. Kir	nd of Business/I	ndustry
2		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o	()	nnig	_		
2	filed within I Hygiene. other than rent, the M		17. Father's Name (First, Middle, Last)		Home	maker	18 Mothar's Na	m <i>e (First, Middle</i>		ivate	
anc	be de la pa	o Be	Albert A. Tibbs				Mary A.		, Maidell .	Somanne)	
<u></u>	d 2 should be th and Menta 7 is marked traumatic ev	T <sub>o</sub>	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street a			er, City or	Town, State, Z	ip Code)
Š	2 6 7 5		Peggy E. Stevens/I	Daughter	5009	Woodland	Blvd Ox	on Hill	MD 2	0745	
Baltimore, Maryland 21215-0036	Pages 1 and nent of Healt int: If Item 2: iry or other i		20a. Method of Disposition  14 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State Fre	<sup>emetery, cren</sup> e Bap	sition (Name of natory or other place tistcemet	ery a_a	Date - 2006		eation - City or 1	Town, State
	permit. Page Department Important: II eny injury o	- 1	21. Signature of Funeral Service Licen:	CONTRACT OF THE PARTY OF THE PA	hurch	. Name and Addres	ss of FacilityPor	e Funer	al Ho	ome	
m	F 5 F 6 8		Valoris!	2 xamo	26	17 Penn A	ve SE Wa	ashingto	n DC	20020	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	n. Do not ente	er the mode of dyin			ırrest,		Approximate Interval Between
Single	Physician		Immediate Cause (Finat disease or condition resulting in death)	· Congesti	re	) Karl	fail	we			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	, ,					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence or):						
	outed ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
Ö,	death certificate be executed e ettending physician and id for use as the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
68760,	cate b	edical		d							
-	eath certific ettending p I for use as		IF FEMALE:	23c. If yes, outcome of pregna	ncv					3d. Date of deli	wan.
Box	death etten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Oth <i>er (specify)</i>			-	Month Month	Day Year
o.	res that the de signed by the e be detached t	hys	9 Unknown	9□ Unknown							
_	law requires that the es been signed by th 2 should be detache	<b>by</b> P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.				the cause of death?
ord	w require been sig should b	ted						1	Yes 2	<b>Uni</b> 3□Pro	obabiy 4 Unknown
Vital Records,	0 5 0	Completed						24a. Was		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
ē	certificete	e လ	25. Was case referred to medical				Of Diese of De	1 ☐ Yes	2 1 No		2 No
	ysician: is certific director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth		dome 5 DResi		□Other (Spec	ufv)
ō	Attending Physician: or death. ector: After this certific by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		28d. Describe			
S S	kttendir death. ctor: Al	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □No				
Division of	o at a	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office			Street and wn, State)		ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled		(Check only 2 Medical Exam	ysician: To the best of my knowings: On the basis of examinat	wladge, deeth	occurred at the tin	na, date and place pinion, death occi	and due to the urred at the time	cause(s)	and marner as	to the cause(s)
	To the h within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licensi				signed (Month	
)	7. W. T. O.		200. Signature and time of contribut	MARNI	1.10		219/1		O)	- O-	, cay, reary
1			30. Name and address of person who of	completed cause of death nem	23a) (Type	Print)	×1759	2	1	D	06
1	4	1	EDWARD L.	MOSLELI	/(	111	6100d	Lau	4/6	vay 1	Bowne 2012
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signar	ture	1.					2013
. 7	Registr	ar	SEP 1 2 2006	Blow A	HOS						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** EULA SHANNON SEPTEMBER 7 2006 MAE 7:20P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOLY CROSS REHAB CENTER BURTONSVILLE PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JUNE 15 **Funeral** 1 M 2 A F Director 81 SOUTH CAROLINA 248-38-1747 1925 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r Itams 23a or 28a-f show driver, ust be notified at 1X Yes 2 □ No Completed by Funeral Director MDPRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1112 HILL ROAD 20785 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mertal Hygiene.
ant: if item 27 is marked other than "natural; or Item ury or other traumatic event, Itte Machical Exacting ury or other traumatic event, Itte Machical Exacting ury. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 X Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER PRIVATE 4th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SARAH CHARLIE BELK FORD P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANIE LEE/DAUGHTER 1112 HILL ROAD LANDOVER MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. HARMONY CEMETERY 4 □ Donation 5 □ Other (Specify) 9/15/2006 LANDOVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer metastat /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ng physician and as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 1 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hou To tha Funa completely fil (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Laren L. Baltt, M.D. DO058676 8,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 25 Main street Suite 200, Babitt 31. Date filed (Month; Day, Year) . Registrar's Signature State Registrar 2 2006

200		For State Registrar  1. Decedent's Name (First, Middle, Last,	State of Maryland /	•	t of Health an e of Death		eg. No.	3. Time of Death
Physicia /Medic		MARTHA E. SHI	EPHARD			SEPT.	6 200	
examin uneral rector	× ,:	4a. Facility Name (If not institution, give PRINCE GEORGE'S 5. Social Security Number 6. Security Number	HOSPITAL CEN	TER C			PRINCE OF STREET	
If item 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event. If a Mudical Exposprat must be notified at	2	Usual Residence of Decedent  10a. State 10b. County		own or Location				10d. Inside City Limits 1     1
Il be notifi	i Director	MD PRINCE Of 10e. Street and Number 2916 BRIGHTSEAT	RD. #202	10f. Zip	Code 20706		Og. Citizen of What C	
	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	13. Was Dece	dent of Hispanic Origin orly Cuban, Mexican, F	? (Specify Yes or No- querto Rican, etc.)	14. Race - Am Black, Whi	
	Completed	15. Decedent's Edu (Specify only highest grad		Sa. Decedent's Usu: (Give kind of wo life. DO NOT us	rk done during most of	f working	16b. Kind of Business	·
100	To Be C	17. Father's Name (First, Middle, Last) WILLIAM J. SHE	EPHARD			Name (First, Middle, I		
er treums		19a. Informant's Name/Relationship (T) DAVID UPSHUR/S	SON L	620 ROOS	SEVELT AV	E., LAND	OVER, MD	20785
eny injury or other tre once.		20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ F  4 □ Departion 5 □ Other (Specify)	Removal from State HARM	of Disposition (Nartery, crematory or o	ther place) PARK 9	-11-06	20c. Location - City or	, MD
eny in		21. Signature of Funeral Service Licens	Chris falle	4 1425 N		AVE., N.I		D.C.20002
cian dical liner	edicai Examiner	23a. Paril. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	idiac i	arrhyth	nia		Approximate Interval Between Onset and Death
מוסמוס הם תפומכוופס המם שמ	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1				23d. Date of de Month	olivery Day Year
Id be deta	þ	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying o	ause given in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
page 2 shou	Completed					24a. Was a autops perform	sy prior to ned? death?	utopsy findings available completion of cause of
irector.	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ② No	Hospital: 1 ☐ Inpatient 2 🛍 ER/	Outpatient 3 DO	1.4	Death Check only on		
completely filled in by the funeral director, page 2	Certification: To	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be			28c. Injury at Work?  1 Yes 2 No	28d. Describe ho	ow injury occurred	ecity)
illed in by		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	v		City or Town	1924	
ampletely t	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phy (Check only one)  2 ☐ Medical Exami	sician: To the best of my knowled iner: On the basis of examination and manner stated.	and/or investigation	at the time, date and position, in my opinion, death	occurred at the time, d	ate and place, and du	e to the cause(s)
$\tilde{n}$		30. Name and address of part in which	ompleted cause of death (Item 23)	a) (Type, Print)	D58957		9-8-06	20185
//		A Gary Lottle	3000 1 /	fispeta	0 /	11.	. 0 (h-1	2 40 -

Plea

ase Type or Print in Black Indelible Ink. Ensure A		
State of Maryland / Department of Health and N	Mental Hygiene 2006	30244
Certificate of Death	Reg No	

2. Date of Death

Day

Month

3. Time of Death

	Dhysisian
	Physician /Medical
)	Examiner
	Funeral

For State Registrar

1. Decedent's Name (First, Middle, Last)

Director filed within 72 hours after death with the Maryland

r than "neturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at injury or other treumatic event, permit. Pages 1 and 2 should be Depertment of Heelth and Mental Important: If Item 27 is marked o

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Š

attending physician and for use es the burial-tran ed by the this After Director

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

6, 2006 SEP John Thomas Stang 0500 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Fairland Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 10XM 2□ F 75 Yrs MAR 15, 220-28-5478 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 Fairland Road 20904 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Korea 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: ğ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kmd of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Aircraft Owners and Elementary/Secondary (0-12) College (1-4or 5+) Pilots Assoc. 10 Press Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Stang Frances Cleveland Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Walters/Nephew 13813 Ideal Circle Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 9/7/2006 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, P.A.
1933 Gist Ave., LL, Silver Spring, MD M00956 20910 23a. Part 1. Enter to Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Diabetes Mellitus Type 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 21 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ٩ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 9/6/2006 an & 0 4 30. Name and address of person who completed cause I death (Item 23a) (Tyre, Print) 1517 Hugo Circle Silver Spring, MD 20906 Alan R. Segal 32 Abgistrar's Signature 31. Date filed (Month, Day, Year) State 2006 8 Registrar

within 24 hours a To the Funerel [ INA

after

			For State Registrar	State o	of Marylan		artment			and M	lental Hygi	ene g. No.2	በፍ	30245
	Physicia	an	1. Decedent's Name (First, Middle		_						2. Date of Death	1	Year	3. Time of Death
	/Medic	al	Dorothy B.  4a. Facility Name (If not institution				4h City	Town or	Location of	of Death	9/3/2	4c. County	of Death	12:45 PM
	Examin	er	Brighton Garde						Chas				gome	ry
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 8/14/1	Year)	9. Birthp Coun	ace (State or Foreign
	Director		101-03-6546 Usual Residence of Decedent	-X	93	115.					8/14/1	913		NY
	aryland show		10a. State 10b. County		10c. City	, Town or Lo	cation						11	0d. Inside City Limits 1 XYes 2 □ No
	the Ma	ecto	MD Montg	omery	Ch	evy Ch	ase 10f. Zip	Code			10	g. Citizen of V	What Coup	
	3a or	直	5555 Friendship	Blvd Apt	# 622			2081	5			United		•
	r deat	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U. prces?	S. 13.	Was Deced f Yes, spec	ent of Hi	spanic Ori	gin? (Spe	ecity Yes or No- Rican, etc.)		e - Americ	
36	rs afte	by Fu	1 Never Married 2 Marr 3X Widowed 4 Divorced	ied 1 □ Yes If Yes, Gi Year or D	2.⊡NNo ve	ŀ	1 ☐ Yes 2		Specify:			Specify		White
2-0-6	72 hou natura lical E	ted	15. Deceden	's Education		16a. Dece	dent's Usua kind of wor	l Occupa	ition	t of worki	ing 1	6b. Kind of Bu	siness/Inc	
121	within ne.	Completed	Elementary/Secondary (0-12)	College (		life. I	DO NOT us	e retired,	)	O WOR	, ig	Mode	0.01	
2	filed v Hygie other t	e Co	17. Father's Name (First, Middle,	Last)		N	urse		18. Mothe	er's Name	(First, Middle, N	Medi		-
/lan	Mental Mental arked artic ev	To Be	Ephraim Birnbau	m					Anr	na Ma	andelker			
Man	alth and 127 is ma		19a. Informant's Name/Relations Anita Eichler -								PH 18-1			<sup>Code)</sup> se MD 20815
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show ery injury or other treumatic event. The Medical Examination untilling at once.		20a. Method of Disposition  1    Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)		State Jud	lace of Dispo ean Me	sition (Nam natory of of MOTIA	ne of Her place	rdens			Oc. Location - Olney M		wn, State
Balti	permit. Departm Imports eny inju		21. Signature of Funeral Service	Licensee							Direct:			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on o	caused the death								00.72	Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition resulting in death)	a		umonia							- 1	Onset and Death I Week
	/Medical Examiner		resulting in deathy	Due to	or as a consequ Fai.	uence of): lure t	o Thr	ive						3 Months
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Jue to	(or as a consequ	reripe of):							-	
	Attending Physician: The law requires that the death certificate be executed rideath.  sctor: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ	ience of):								
8760,	ate be ohysicienthe buri	cal		d										
9 x	certificanding pt	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, ou	tcome of pregna	ncy						23d Dat	e of delive	rv
J. Box	at the death certific I by the ettending parached for use as	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		oirth 2 ∏ Fetal nant at time of de own		Ectopic pre Other (spe					Moi		Day Year
0.0	res that th igned by be detach		Part II. Other significant condition	ns contributing to d	eath but not resu	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did tob	acco use conti	ibute to th	e cause of death?
rds	w requires been sign should be	ed by									1 🗆 Yes	s 2 No	3 Proba	ably 4 Unknown
ec0	law reas bee	Completed									24a. Was an	24b. V	Vere autop	sy findings available
<u>=</u>	: The cate h										perform	ed?	leath?	2X No
<u>=</u>	hysician: The law his certificate has t I director, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	Inpatient 2 🗍	ER/Outpatien	t 3 DO	▲ Othe			(Check only one		(С	Assisted
ס ר	ding Phy Ih. After this funeral c	on; To	27. Manner of Death	28a. Date	of fnjury th, Day Year)	28b. Time of fnjury		Bc. Injury Work			28d. Describe hor			Living
Sio	r Attendir er death. rector: Af by the fu	catlc	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation			М	1 🗆 1	′es 2 🗆 I					
Division of Vital Records,	afte all in I	Certification;	4 Homicide determ	ned 288. Place	of Injury - At ho ing, etc. <i>(Specif</i> y	me, farm, str	eet, factory,	, office			28f. Location (Str. City or Town,		er or Rurai	Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the		29a. Certifier 1 XCertifyin (Check only 2 Medical	g Physician: To the	best of my know	wledge, death	occurred a	at the tim	e, date an	d place, a	and due to the car	use(s) and ma	nner as sta	ated.
	the H hin 24 the Fi	Medical	one)		ner stated.	ion and/or in				in occurr				
	Co Twit		29b. Signature and title of certified	+ (	Q .		290.		number 00601	29		d. Date signed Septeml		
1	12 (I)		30. Name and address of person	who completed caus	se of death (Item	23a) (Type,	Print)							
			Brent Cole I					30 C1	nevy	Chas	e MD 208	15		
	Sta Registr	-	31. Date filed (Month, Day, Year)	2006	Registrar's Signal	1 40	yes)							

DHMH 17 Rev 1/2001

573

State Registrar

31. Date filed (Month, Day

Signature

2001 Med Parkway Annap MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stauzione

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2006

			1 - For State Registrar	State of Ma	aryland / De	partmer		and Menta	Reg		
	Physici	an	Decedent's Name (First, Middle			Caranasah		Mo	te of Death onth	Day Yea	3. Time of Death
	/Medio	al	Ivor	William		Strawb			prembe	er 1 200	
	Examir	er	4a. Facility Name (If not institution,				Town, or Location	or Death		Anne A	
	Funeral		5. Social Security Number		e (In yrs. last birthda	y) If Unde	ly Side	24 Hrs. 8. Da	te of Birth		Birthplace (State or Foreign Country)
en la	Director		220-38-3792 Usual Residence of Decedent	<b>XX</b> M 2□ F	73 Yrs.	Months	Days Hours	Min. Jan	te of Birth onth, Day, Yo 5 191	933 W	ales
	Marylan a-f show	tor	MD Anne A	rundel	10c. City, Town or Shady						10d. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28a st be not	Funeral Director	10e. Street and Number 4997 Lerch Driv	re		10f. Zij	20764		10g	. Citizen of What USA	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 le marked other then "natural", or Items 23a or 28a-f show any figury or other traumatic event, the Modical Examinar must be notified at once.	by	11. Marital Status  1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ad 1 Tyes 2 1f Yes, Give Year or Dates:	Ever in U.S. 1		dent of Hispanic Ori cify Cuban, Mexical 2 XNo Specify:		es or No- etc.)	14. Race - Ar Black, W Specify:	mencan Indian, hite, etc. White
21215-0036	thin 72 ho e. en "natur	Completed	15. Deceden!' (Specify only highes: Elementary/Secondary (0-12)	s Education grade completed)	(G.	cedent's Usu ive kind of wo a. DO NOT u	al Occupation ork done during mos use retired)	st of working	16	b. Kind of Busine	ss/Industry
2	ed wil	Con	12		Own	er				Applianc	e Store
nd	be fill d oth	Be	17. Father's Name (First, Middle, L					er's Name (First,			
3	ould J Men narke	2	William Levi St		40. 14	D: 4.44		rissa Ma			
Maryland	d 2 st th and 7 le n traun		19a. Informant's Name/Relationsh Theresa B. Stra				s (Street and Number) ch Drive,				e, Zip Code)
	1 and Healt tem 2		20a. Method of Disposition	wbildge (wi	20b. Place of Dis			Date		c. Location - City	or Town, State
<u>S</u>	ages ant of it: If It		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Our Lad		1	9-6-200			
Baltimore,	nit. P eartme ortan injur		21. Signature of Funeral Service L		Our Lau	<del></del>				Vest Riv	=1, MD
ñ	Departiment Department		Fatal 2	all		Hard 12 R	nd Address of Facili lesty Fune Lidgely Av	eral Hom	e, P. <i>A</i>	lis. MD 1	21401
	3		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that caused only one cause on each line	ne.	enter the mod		cardiac or respi			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequence of):	11 2	C 017(2 C)				six monnt
100		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):						) ( ) ( ) ( ) ( ) ( ) ( )
8760,	rate be executed thysician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	c	a consequence of):						
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s <sub>f</sub>				23d. Date of o	delivery Day Year
	quires that n signed t uld be det	þ	Part II. Other significant condition	ns contributing to death b	ul not resulling in the	underlying o	cause given in Part I	I. 23	le. Did tobac		to the cause of death?  Probably 4 □Unknown
I Records,	The law requir ate has been si page 2 should	Completed							a. Was an autopsy performed	prior t death	
Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					e of Death (Chec	k only one)		
of\	hyel this c	2	1 Yes 2 No	Hospital: 1 Inpatie						e 6 □ Other (S	pecify)
ion o	Attending F r death. ector: After by the funera	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	ation	ry Year) 28b. Time y Year) Injur	of y M	28c. Injury at Work? 1 □ Yes 2 □		escribe how	injury occurred	
Division	tal or Attendi s after death. si Director: A ed in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determin		ury - At home, farm, c. (Specify)	street, factor	y, office	28f. Loc Cit	cation (Stree y or Town, S	et and Number or State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier Certifying (Check only one)	Physicien: To the best xaminer: On the basis of and manner sta	f examination and/or	eath occurred investigation	at the time, date and, in my opinion, dea	nd place, and due ath occurred at th	to the caus le time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	e M	4	29	c. License number		29d.	Date signed (Mo	nth, Day, Year)
			V/L	1//	W		20051	1307	50	sten bo.	1,2006
	41		30. Name and address of person v	the completed cause of d	leath (Item 23a) (Typ DBCNY G	pe, Print)	7300	Anna	rolps,	MO 21	401
*	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7	2006 32 Registr	ár's Signature	back .	,	7	7		

State of Maryland / Department of Health and Mental Hygiene, 30248 For State Registra Certificate of Death Reg. No 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** sep. 2, 2006 3:38 a M John J. Shields /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 522 Charington Drive Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 72 067-26-4000 Yrs Director NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be nutified at MD Anne Arundel Severna Park 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 Charington Drive 21146 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 57 Yes 2 □ No 1951 – If Yes, Give Year or Dates: 1954 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Bureau of Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing & Engraving 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is markad oth any linjury or other traumatic event SDRS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Shields May Adair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Jayne Shields/Wife 522 Charington Drive, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Sep. 6, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 4 □Donation 5 □Other (Specify) Baltimore, MD 2006 22. Name and Address of Facility Barranco & Sons, 21. Signature of Funeral Service Licensee P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2500 1 Yes 1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Yes 2540 ဥ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21438 tedicause of death (Item 23a) (Type, Print) DEFENSEH m 45 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar

		1 - State Registrar			Cer	tificate of	Death		F	leg. No.	200	0	302	. 7 /
Phys	sician	Decedent's Name (First, Middent)  Thermoder  Therm			hull				2. Date of Dea Month	Day	Yea		3. Time of De	
/Me	edical	1 C Th M (f and in the ci	Spaulding		NILLI I	4b. City, Town,	or Location o		August 2		006 County of D	eath	4:00	A M
Exa	miner	Ginger Cove Healt	h Center			Annapolis	5			An	ne Arun	del		
Fune Direct		5. Social Security Number 579–16–5252	6. Sex 1 M 2 □ F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Min.	B. Date of Birth (Month, Day September	. Year)		Country	ington,	
aryland ahow	,	Usual Residence of Decedent  10a. State  10b. Count			Town or Loc	cation						10d	Inside City I	
the M	recto	Maryland Anne A	runcel	Annag	DLIS	10f. Zip Code				10g. Citiz	zen of What	Country		X
ath with 23a or	Funeral Director	4215 River Cresco	nt Drive			21401				Unit	ed Stat	es		
ter de:	a Cili	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed Ford		13. V	Vas Decedent of I Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)	1	4. Race - A Black, W			
ours at	2	3 ₩idowed 4 Divorce	If Yes, Give	,	1	☐ Yes 2X No	Specify:				Specify: W	hite		
n 72 h	Completed	15. Decede (Specify only high	ent's Education lest grade completed)		16a. Deced (Give I	ent's Usual Occu kind of work done OO NOT use retire	pation during mos	t of working	9	16b. Kir	nd of Busine	ss/Indus	stry	
d withi		Elementary/Secondary (0-12)	College (1- 5+	4or 5+)		ical Engir				Elec	trical	Engir	neering	
Janua Jid be file Aental Hy rked other	To Be	17. Father's Name (First, Middle							(First, Middle, livia F					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 21 a marked other than "natural", or iteme 23a or 28a-f ahow any Injury or other than "natural", or iteme 23a or 28a-f ahow any Injury or other traumatic avant. The Medical Exeminer may be notified at		19a. Informant's Name/Relation	nship <i>(Type, Print)</i> Claughter)			g Address <i>(Stree</i> DX <b>5015</b> Ar				-	Town, State	e, Zip Co	ode)	
Ses 1 a		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	n 3 □Removal from S	tate	netery, crem	sition (Name of natory or other pla	ice) Z	August August	30,	20c. Lo	cation - City	or Town	n, State	
mit. Pages partment of portant: If it		4 □ Donation 5 □ Other (		Metrog		. Crematory  . Name and Addre	1	2006	nt Filmera	Alex	andria, Tramati	Vir.	ginia Przice	
Deperment	Buce	Design	200	M00982	1000000	Hudson St								
Physici	aii	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition	or complications that ca st only one cause on ea	used the death.	Do not ente	er the mode of dy	ng, such as	cardiac or	respiratory arr	est,		In	pproximate iterval Between Inset and Dea	
/Medic Examin		resulting in death)	Due to (c	or as a conseque	nce of):							0	<i>y</i>	
pe tist	Jiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as a conseque	nce of):									
artificate be executed ing physician and east the burial-transit	ai Examiner	resulting in death) Last	cDue to (c	or as a conseque	nce of):						<del></del>			
ficate physics the last	Medical		d											
DIVISION OF VICE INCOMES, IT.O. DOX 00 / 00.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely lifted in by the funeral director, case 2 should be detached for use as the burial-transit	Physician/M		1 ☐ Live bir	ome of pregnance th 2 ☐ Fetal de ant at time of deal wn	eath 3 🗌	Ectopic pregnand Other (specify)	ey .			2	3d. Date of Month	delivery Da	ay Yea	ar
uires that n signed b	20 70	Part II. Differ significant condi	tions contributing to dea	ath but not resulti	ing in the un	nderlying cause gi	ven in Part I			bacco us		e to the	cause of dea	
The law requir	Completed								24a. Was a autop: perfor	sy	death	autopsy to comp	y findings availetion of caus	ailable se of
cian:	B o	25. Was case referred to medic examiner?							(Check only or	10)	l			
Physic rthis c	F		Hospital: 1 ☐ In  28a. Date of (Month)		VOutpatient 8b. Time of	3 DOA			e 5 Resid			Specify)		
ath.	atlor	1 Natural 5 ☐ Pend 2 ☐ Accident inves	ding (Month stigation	n, Day Year)	Injury	28c. Inju Wo M 1	rk? ]Yes 2∐			. ,				
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely flied in by the funeral director, ages 2.	Certification.	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	mined 289. Place	of Injury - At hom g, etc. (Specify)	e, farm, stre	eet, factory, office		28	3f. Location (S City or Tow	treet and n, State)	d Number or	Rural R	loute Numbe	Γ,
na Hospit n 24 hour na Funera	Madical		ring Physician: To the last Examiner: On the baar and mann	sis of examination	edge, death n and/or inv	occurred at the t restigation, in my	me, date an opinion, dea	nd place, an ath occurred	nd due to the o	ause(s) late and	and manner place, and o	as state due to th	ed. ne cause(s)	
To the To the To the Company	A	29b. Signature and title of certif	ier ) Al	e Au	1	29c. Licen	se number	143	8	9d. Date	signed (Mo	onth, Da	y, Year)	16
	0	30. Name and address of person	n who completed cause	of death (Item 2	3a) (Type, I	Print) DE	FEN	SEF	hattu	/Ay	ANN	APO	LIS M	1044
Rec	State istrar	31. Date filed (Month, Day, Yea		gistrar's Signatur	e A	and a								
DHMH 17 Rev			2 2000		- Ag									

			1 - State Registrar	State of Marylar	Ce	rtifica	te of D	eath		Reg. No.	06 30	1250
	Physici	an	1. Decedent's Name (First, Middle, Last,						2. Date of De Month	Day	Year	of Death
	/Medic Examin	-	Anna Mae SHIFFLE' 4a. Facility Name (If not institution, give			4b. Cit	. Town, or Lo	ocation of Deat		000 10 2	006 94:	<u> </u>
	Funeral	eı	Washington County 5. Social Security Number 6. Se	/ Hospital	last birthday)	If Und	Hage or 1 Year	VStore	8. Date of Bir	Was	hingto: 9. Birthplace (State	
	Director		312-40-6812	м 2 <b>X</b> IF 63	Yrs.	Months	Days	Hours Min.		y, Year) 20 1942	Country) Maryland	
	g ,		Usual Residence of Decedent  10a. State 10b. County		ty Town as I							
	anyla ehov	5			ty, Town or Lo						10d. Inside	es 2 🗆 No
	the M	ect	Maryland Washing  10e. Street and Number	on	Hage		n ip Code		I	10g. Citizen of W		
	with with	흐	4	) to 1		101. 2		<b>,</b> 0		USA	nat Country :	
	ne 23	Funeral Director	42 East Avenue – A	12. Was Decedent Ever in U	.S.   13.	Was Dec	217 adent of Hisp		specify Yes or No to Rican, etc.)		- American Indian,	
Maryland 21215-0036	d within 72 hours after death with the Maryland Jiene. I than "natural", or iteme 23a or 28a-f ehow I'na Mozical Exarili ar must be motified at	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:				Mexican, Puer Specify:	to Rican, etc.)	Specify:	white, etc. White	
Š	2 hou		15. Decedent's Edu		16a. Dece	dent's Us	ual Occupation	on	dina	16b. Kind of Bu		
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	ring most of wo	ixing .			
21		Co	12	0		Home	maker				wn home	
and E	ed in a	Be	17. Father's Name (First, Middle, Last)				1			Maiden Sumame	9)	
₹ Z	should b and Menti marked umatic	ဥ	John Wesley Burdet		10b Maili	a Addra	/Stroot no		s Renner	er, City or Town, S	State Zin Code)	
Ma	d 2 tra		Grandle Funeral Ho							inia 228		
	ges 1 and 2 should t of Health and Men If Item 27 Is marke or other traumatic		20a. Method of Disposition	20b. F	Place of Dispo	sition (N	me of	DIOGGW	Date VIIE		City or Town, State	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crei Havret			dens 9/	14/06	Harrison	burg, Va	
Ħ	orter		21. Signature of Funeral Service Licens				nd Address			Funeral		•
ä	Depar Impo		I Tred Lives	Tal	4	15 E	. Wils				Md. 21740	)
			23a. Part1. Enter the disease, or complishock, or heart lailure. List only of	ications that caused the deat	th. Do not en	er the mo	de of dying,	such as cardia	or respiratory a	rrest,	Approxim Interval B	
	Physician		Immediate Cause (Final disease or condition	Reshi	valor	. 1	Evil	avo			Onset an	d Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):	7	- 0 (5-	. 4				
	Examiner	_	Sequentially list conditions,		monia						20	)
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	. ,	L .	1 5	allun			1 1	V
_	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as consec		reay	1 (c	C L L W Y	٤		- 1	<u>/</u>
68760,	ificate be executed g physicien and as the burial-transit	aiE										
89	= On od	edlcai						11 - 111				
Вох	death cert e attendin ed for use	M/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		Tetenio	pregnancy			23d. Date	ol delivery	
	that the death cert ed by the attendin detached for use	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 🖾 No	4 Pregnant at time of o		Other (				Mon	th Day	Year
P.O.	at the	Phy	9 Unknowń									
	w requires that the sbeen signed by the should be detache	by	Part II. Other significant conditions con	ithouting to death but not res	suiting in the u	naeriying	cause given	in Part I.			bute to the cause o 3 ☐ Probably 4 [	
of Vital Records,	requi	Completed				·			100		3   Frodably 4	ZUTKTOWT
Sec	has 30.2	mp							24a. Was autop	osy pi	fere autopsy linding for to completion of eath?	
a	icien: The li certificate ha								1 ☐ Yes	2 1 No 1	Yes 2 No	
₹		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	fospital: 1 Inpatient 2	ED/Outpation	• 200	0.4		ath Check only o	-1	. (0 ()	
ō	Phy ar this eral d	5	27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injury a Work?			dence 6 Othe		
<u></u>	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м		s 2 No				
Division	il or Atte after des Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, larm, str fy)	eet, facto	ry, office		28f. Location (S City or Tox		r or Rural Route Nu	mber,
	To the Hospital or Attending Physical within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edicai C		sician: To the best of my knoner: On the basis of examinating and manner stated.								e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			2	c. License n	number		29d. Date signed	(Month, Day, Year)	
			mes				05	-327		9/11	4	
ر ي	1 1		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,	Print)				,	3	
51	1-3		Dr Wasien	1126	Opal	Co.	ut		rg. 140	1-217	40	
	Sta Registr		31. Date filed (Month, Day, Year)  CED 1 2 2	32. Registrar's Signa	ature	1 ,			l			

06

6-06616	Please Type or Print in Black Indelible Ink ਹਵਰਤ of Maryland / Department of Health and Mental Hygiene											
aul Henry Sohr	•	1- For State	ادت کا Maryla		tment of ficate of		Mental H	Reg. No. 2006 3025				
Physicia		Registrar  1. Decedent's Name (First, Midd	le,Last)					2. Date of De	ath	3. Time of D	eath	
Medical Exami		PAUL HENRY SOF				- O'to T 1			er 5, 2006	1100 h	rs	
		4a. Facility Name (if not institution Port Deposit Marina F		imber)	4	b. City, Town, or Lo Port Deposit		1	4c. Count	y of Death		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24Hrs	_	irth(MM/DD/YY)	9. Birthplace (State Foreign	or or	
Director	Į	220-48-3065	1 <b>X</b> M 2 F	49	Yrs.	Months Days	Hours Min		5/1957	Country) MI	)	
any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Location	on				10d. Inside	City Limits	
ž .	٦	MD OUEEN	ANNE'S	GRASO	ONVILLI	7				1 Yes	2 <b>X</b> No	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	1 1111111			10f. Zip Code			10g. Citizen of V	Vhat Country?		
th the ? 23a or notifie		326 GREENWOOD				21638		USA				
ath wi	Funeral	11. Marital Status 1 Never Married 2 X M	arried Armed F			Decedent of Hispa es, specify Cuban, I				ce - American Indian, B ite, etc.	lack,	
ifter death il", or ite		3 Widowed 4 Div	orced If Yes, Give Year or Dates:	2 X No	1	Yes 2 X No	specify:		Specify	WHITE		
hours a	ed by	15 Decedent's Education (Spe	ecify only highest grad			's Usual Occupationst of working life. I			16b. Kind of E	Business/Industry		
36 nin 72 e. than "	plet	Elementary/Secondary (0-12)	College (1		ATDCDAI	PP MECHAN	T.C		ATDIT	NE COMMEDO	T AT	
215-0036 be filed within 7. ntal Hygiene. rked other than ent, the Medical	Completed	17. Father's Name (First, Middle			ALKUKA	FT MECHAN		e (First, Middle,	Maiden Surnam	NE COMMERC	IAL	
21 oc fil ital l	Be	HARRY SOHN			AMELIA							
MD 21 Id 2 should but and Mer In 27 is mar aumatic eve	۴	19a. Informant's Name/Relations  KIM A. MOHR SO		CF.				wn, State, Zip Code) E, MD 2163	8			
4 E E B B	ŀ	20a. Method of Disposition		20b. Pla		tion (Name of ceme		Date		n - City or Town, State		
Pages I nent of F ant: If i		1 Burial 2 X Cremation 4 Donation 5 Other S		OIII State	•	CREMATI	ON 09/	07/200	STEVEN	SVILLE, MD		
Baltimore, permit. Pages I a Department of He Important: If ite injury or other t		21 gn up of 50 rai Service	the second secon	7	22. N <b>FE</b>	ame and Address of LLOWS, HE	of Facility LFENBET	N & NEW	NAM FUN	ERAL HOME,	P.A.	
Physician		23a. Part I Enter the disease, or		aused the death. D		SHAMROC e mode of dying, si				eart Approxima		
/Medical	0.7	failure. List only one cause Immediate Cause (Final disease	D							Between (	Onset and ath	
Examiner		or condition resulting in death)		consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate		a consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):								
ecuted and transit	al Ex	events resulting in death) Last	d									
		UNPENDED	AMENDED									
Box 68760, e death certificate be the attending physic ed for use as the bur	sician/Medic	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregna	-	al death 3	Ectopic pregna	ancv	23d. Date of Month	of delivery Day	Year	
ox 687 eath certific	sicia	past 12 months?  1 Yes 2 No 9 Un	4 Pregr	nant at time of deat	h -	ner (Specify)		,		,		
the dea	Phys	Part II. Other significant condit	9 Olikii		ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to the cause of	death?	
cords, P.O. B law requires that the d has been signed by the 2 should be detached	Š				g	,		1Y	es 2 No	Probably 4	Unknown	
rds, requir been s	Completed				-			24a. Was		. Were autopsy finding prior to completion of		
He law ate has age 2 s	ошо								ormed?	death? 1 ✓ Yes 2	No	
Vital Rec ysician: The l his certificate l	Be C	25. Was case referred to medica examiner?					of Death (Check	only one)	hammed			
F Vit Physic or this or	5	1 🗸 Yes 2 No			R/Outpatient	0 000		ng Home 5		Other: Scene		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ray after death  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ion:	27. Manner of Death  1 Natural 5 Pen	28a. Date (Mont) Sep 3, 2	Day Year)	28b. Time of Ir 1422 hrs		es 2 V No	Subject dro	how injury occu owned	irrea		
r Atter rer dea irector n by th	ficat	2 🗸 Accident Inve	estigation	ce of Injury - At hom	ne, farm, stree	t, factory, office but	ilding, etc.			ber or Rural Route Nu	mber, City	
Div pital o ours af	Certification:	4 Homicide dete		River				or Town, Susquehar	state) nna River, Po	ort Deposit, MD		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		(Official Office)	Physician: To the beaminer: On the basis	-								
To tl withi To tl	Medical	29b. Signature and title of certific	and manner s			29c. License				ned (Month, Day, Year	r)	
		Carol	4/Q	e Qa	_	O.C.M	1.E.		Septembe	er 6, 2006		
		30. Name and address of person					9197					
		Carol Allan, MD As	ssistant Medical	Examiner 1	11 Penn S	street, Baltimo	re, MD 2120	)1				

State 31. Date filed (Month, Day, Year) 7 200b 32. Redistrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death

30252

F	Exami uneral	
fer death with the Maryland	ritams 23a or 28a-f ahow instrmust be notified at	Funeral Director

	Physician		Decedent's Name (First, Middle, Last)			2. Date of D Month	Day Year	3. Time of Death
	/Medic Examir	al	Wilhelmina Sto 4a. Facility Name (If not institution, give street a Frederick Memorial Ho	4b. City, Town, or Location of Death Frederick		ember 16, 2006 7:25 AM  4c. County of Death  Frederick		
Ī	Funeral Director		5. Social Security Number 6. Sex 1 □ M 20	7. Age (In yrs. last birthday 95 Yrs.		Jnder 24 Hrs. 8. Date of B Oct.	irth Pay Year 1910 Mary	place (State or Foreign nto) Tand
Maryland 21215-0036	death with the Maryland ms 23s or 28s-f show Invel be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick	10c. City, Town or L Frederic				I 0d. Inside City Limits 1 Yes 2 ☐ No
	3s or 28		10e. Street and Number 6441 Jefferson Pike		10f. Zip Code 2170	03	10g. Citizen of What Cour	ntry?
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylar Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examiner must be notified at once.		1 Never Married 2 Married 1 If You	s Decedent Ever in U.S. ed Forces? Yes 2 0 No ss, Give r or Dates:	If Yes, specify Cuban, M	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	Black, White,	
	ithin 72 ho ne. "natur Medical			ege (1-4or 5+) (Given life.	edent's Usual Occupation e kind of work done durin DO NOT use retired)	g most of working	16b. Kind of Business/In	dustry
	be filed w ital Hygier id other th		8   17. Father's Name (First, Middle, Last) John William S		memaker 18.	Mother's Name (First, Middle Gertrude Sim		
	nd 2 should alth and Mer 27 is marks r traumatic		19a. Informant's Name/Relationship (Type, Prir James M. Stockman, se	t) 19b. Mail			ber, City or Town, State, Zip	Code)
Baltimore,	Pages 1 a ment of He- ant: If Item jury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal 4 □ Donation ※ ② Other (Specify)	from State	ematory or other place)	Date Sept. 19, 2006	20c. Location - City or To	
Balt	permit. Departimport any inj		21. Signature of Euneral Service Licentee	MOODEE K	22. Name and Address of Leeney and B .06 East Chu	sasford PA Fur rch St., Fred	neral Home Lerick, Md. 2	1 701
Division of Vital Records, P.O. Box 68760,	Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not er e on each line.		ich as cardiac or respiratory		Approximate Interval Between Opset and Death
	certificate be executed by the first seas the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c	ue to (or as a consequence of): ue to (or as a consequence of):				
	certif oding ISB as		in the past 12 months?	os, outcome of pregnancy Live birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
	w requires that the death been signed by the atter should be detached for L		Part II. Other significant conditions contribution	g to death but not resulting in the	underlying cause given in		tobacco use contribute to the	he cause of death?
	The law ate has b page 2 st					per 1 ☐ Yes	opsy prior to co formed? death? 2 No 1 Yes	opsy findings available mpletion of cause of
	ding Physician: h. After this certific funeral director,		25. Was case referred to medical examiner?  1 □ Yes 2 No Hospital  27. Manner of Death 28a.	Date of Injury 28b. Time of	ent 3 DOA Other: 4		sidence 6 Other (Specification)	y)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer		2 Accident investigation	(Month, Day Year) Injury  Place of Injury - At home, farm, sibuilding, etc. (Specify)	M 1 ☐ Yes	28f. Location	(Street and Number or Rura own, State)	v/ Route Number,
			(Check only 2 Medical Examinar: On	To the best of my knowledge, dea the basis of examination and/or in d manner stated.	th occurred at the time, do	ate and place, and due to the n, death occurred at the time	e cause(s) and manner as s e, date and place, and due to	tated. the cause(s)
To the within ? To the comple			29b. Signature and title of certifier  Custin Peurse		29c. License number 0 5 9 6 8 9		29d. Date signed (Month, Day, Year) September 18, 2006	
	14		30. Name and address of person who complete Austin Pearre, M.D	d cause of death (Item 23a) (Type		Frederick, MD	21701	
4	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 2 2006	32 Aegistrar's Signature	asti)			
	UMU 17 Day 1/2	004	***		*			

State of Maryland / Department of Health and Mental Hygiene 2006 30253 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day
SEPTEMBER 7 **Physician** THOMPSON HOMER JR. 2006 9:30 P <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 1 → M 2 □ F Months Days Hours Min Yrs. Director 577-40-0708 75 SEPT 10 1930 GREENVILLE, SC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f shov dical Examiner must be notified at PRINCE GEORGE'S 1 XYes 2 No Directo MD LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Iteme 23a 2712 HAWTHORNE TERRACE 20785 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene Important: if item 27 is marked other than "naturel; or item ony injury or other treumatic event, the M-diral Exercitives ONGs. 1 □X es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No Specify: Specify: BLACK 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12th GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HOMER J. THOMPSON SR. MARTE DITRHAM ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELENE COLE-BROWN/GODDAUGHTER 3217 BROOKLAWN TERR. CHEVY CHASE, MARYLAND 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/12/2006 LANDOVER, MARYLAND HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine PULMONARY EDEMA or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ned by the a e detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign t AORTIC STENOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? PULMONARY HYPERTENSION has 10 2 autopsy 1 Yes 2 No 1 Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural within 24 hours after death, To the Funerel Director: Al completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide the Hospitel 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DW57636 Patrica aven 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AL DR CHEVERIY MD 20983 ATRICIA 31. Date filed (Month, Day, Year) State Registrar

		1- For State of Maryland / De	epartment of Health and N Certificate of Death	Mental Hygiene 2006 30254
Physici		Decedent's Name (First, Middle, Last)     Mary Thomas		2. Date of Death   3. Time of Death   Month   Day   Year
/Medic Examir		4e. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	4c. County of Death  Montgomery
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthoun 1 □ M 2 ☒ F 82 Yrs	(ay) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)  June 23, 1924 South Carolina
Maryland f show led at	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of DC Washir		10d. Inside City Limits 1X☐Yes 2☐No
with the a or 28a.	Direc	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, I've Medical Evantinar must be notified at once.	by Funeral Director	556 Peabody Street NW  11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  1 □ Vess Give Year or Dates:	20011  13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2⊠ No Specify:	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
within 72 hou ane. than "natura the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) (C) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of work fe. DO NOT use retired) Secretary	16b. Kind of Business/Industry
nd 2 should be filed v Ith and Mental Hygie 27 Is marked other r traumatic evant, II	Be	17. Father's Name (First, Middle, Last) Eugene Bookheart	18. Mother's Nam	e (First, Middle, Maiden Sumame)
2 should and Mei Is mark raumatic	₽ P	19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Number or Rui	al Route Number, City or Town, State, Zip Code)
rmit. Pages 1 and partment of Health portant: If item 27 y injury or other ti		20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State		Date 20c. Location - City or Town, State  2006 Brentwood, MD
permit. P Departme Importan any injur		21. Signature of Funeral Service Licenses	22. Name and Address of Facility $Joh$	nson and Jenkins Funeral Home Washington, DC 20011
death certificate be executed  Wedical Examiner e attending physician and of for use as the burial-transit	Ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  C. Due to (or as a consequence of)  Due to (or as a consequence of)	c Cardiovascular	disease (asciv) Interval Between Onset and Death Unknow
the death certifica y the attending ph ached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year
es that igned b	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
The law requir sate has been s page 2 should	Completed			24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
or Attending Physician: The law requires tater death.  Director: After this certificate has been signe in by the funeral director, page 2 should be	ation; To Be	25. Was case referred to medical examiner?  1  Yes	atient 3 DOA Other: 4 Nursing Ho	h <i>(Check only one)</i> me 5 ☐ Residence 6 ☐ Oth <i>er (Specify)</i> 28d. Describe how injury occurred
al or Attence atter death   Director: d in by the	ertification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	s, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, of the desired in the desir		
To th To th comp	Me	29b. Signature and title of certifier  Chow dly, mp	29c. License number D 4 31 21	29d. Date signed (Month, Day, Year) 8/29/06
(6)		30. Name and address of person who completed cause of death (Item 23a) (To NURUL CHOWDHURY, MD 3 15216	DINO DRIVE , BU.	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 1 2006	of i	

			For Stata Registrar	State of Marylan	d / Depa	artment	of Health	and Me	ental Hygi	ene g. No. 2	006	30	255
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last  Donald  4a. Facility Name (If not institution, give	Thems	00		own, or Location	2	Date of Death Month September	Day 4c. Cou	Year 2006 unty of Death	3. Time of	Death A M
	Funeral Director		5. Social Security Number 6. Se 219-64-4277		last birthday)	If Under 1			Date of Birth (Month, Day, OCC • 11				
	he Maryland 28a-f ehow utilied at	ector	10a. State 10b. County Maryland Charle		y, Town or Lo ldorf					Citien		10d. Inside Ci	
36	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. If is marked other then "naturel", or Items 23e or 28e-f ehow treumatic event, the Medical Examinar must be nutified at	by Funeral Director	10e. Street and Number  8789 Cottongra  11. Marital Slatus  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	SS St.  12. Was Deceden! Ever in U Armed Forces? 1   Yes, 2½ No If Yes, Give Year or Dates:		Was Deceder tf Yes, specifi	603  nt of Hispanic O y Cuban, Mexica  XNo Specify			USA 14.	of Whal Cou Race - Ameri Black, White, ecify: Wh	can Indian, etc.	
21215-0036	f within 72 hou liene. r then "nature the Medical El	Completed t	15. Decedent's Edi (Specify only highest grad	ucation	(Give		Occupation done during mo retired)				of Business/In	vernm	ent
Maryland 2	nould be filed d Mental Hygis narked other natic event, the	To Be C	17. Father's Name (First, Middle, Last)  Donald D. Tho		10h Maili	- Add (		bara	First, Middle, M Jean	Wi	throw	- (2- 42)	
	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (T) Nida O. Thomson 20a. Method of Disposition	- Wife	8789	Cott	ongras		,Wald	orf,		0603	
Baltimore,	permit. Pages 1 and Department of Health importent: If item 27 eny injury or other ti once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State Re	surre	ction ction	er place) Cem.		2006	Clin	ton,	Md	
Ba	Depring eny		23a, Part1. Inter the disease, or comp	lications that caused the deat			Address of Facile P. Kallon Hill of dying, such as				me, P	Approximate	е
	Physician /Medical		should, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Am to a  Due to (or as a conseq	-	- lat	1275	501	erosi	2	-	Intervat Bets Onset and I	Death
760,	te be executed with the beautiful transit is burial-transit is burial-transit in the burial transit in the burial transit is burial transit in the burial transit in the burial transit is burial transit in the burial transit in the burial transit is burial transit in the burial transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o									
P.O. Box 6876	death certificate e attending phy: d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Ideath 3	⊒Ectopic preç ⊒ Other (spec				23d.	Date of delive		Year
	T, e law requires that the tte has been signed by the bace 2 shruld be deteche	by	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	inderlying cau	use given in Part	l.	1			he cause of d	
al Reco		Completed	OC Wassers						24a. Was an autopsy perform	ed?		opsy findings : ompletion of c	
Division of Vital Records,	ding Physicii h. After this ceri funeral direct	ation: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatient 2 🗷 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury			lursing Home	Check only one  5 Resider  d. Describe hor	nce 6		fy)	
Divis		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, elc. (Specii	y) 				f. Location (Str. City or Town,	State)			ber,
	To the Hospitel or within 24 hours after To the Funerel Dircompletely filled in	Medical	(Check only 2   Medical Examone)  29b. Signature and title of certifier	vsician: To the best of my knotiner: On the basis of examination and manner stated.	owtedge, dear	ivestigation, ii	the time, date a n my opinion, de License number	ath occurred	at the time, da	te and pla	d manner as s ce, and due to gned (Month,	o the cause(s	)
)	(10)		Manh Lech		n 23a) /Tues	D	0051	765	5	zptz,	mber	7,20	106
2	Sta	ate.	Noah Lecht  31. Date filed (Month, Day, Year)	32. Registrar's Signa	O E	Mony	ment	St.	Baltin	nore	, ML	7/2	205
	Regist		SEP 1 1 2006	32. Registrar's Signa	grant								

			For State Registrar	State of Marylar		artment of F			giene Reg. No. 20 (	06 30256
F	Physici		1. Decedent's Name (First, Middle, L Bruce J. Teck	ast)				2. Date of Dea Month Sept.		3. Time of Death 5:13 P M
	/Medio Examin		4a. Facility Name (If not institution, ga	ive street and number)		4b. City, Town, o	r Location of Dea		4c. County of Montgom	
	uneral rector		224-40-4413	Sex 7. Age (In yrs	,,	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. 1935 N	Birthplace (State or Foreign Country) ew York
IZIS-UUSO within 72 hours after death with the Maryland one.	or 28a-f show se notified at	Director	Usual Residence of Decedent	ery Po	otomac	10f, Zip Code	,		10g. Citizen of Wha	10d. Inside City Limits  Yawayes 2 □ No  at Country?
<b>U.So</b> urs after death w	d other than "naturel", or items 23s or 28s-1 show event. The Medical Examinar must be notified at	by Funerai	10537 MacArthur  11. Marital Status  1 Never Married 2 Married  3XXVidowed 4 Divorced	12. Was Decedent Ever in to Ammed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates:	1	Was Decedent of Hif Yes, specify Cubin	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	USA  14. Race - Black, v  Specify:	American Indian, White, etc. White
N 8 6	erthan "natur t. the Medical E	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+) 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d) Develop untant		Real Est Developm	ate
YIZING Ould be filk Mental Hy	arked other atic event.	To Be	17. Father's Name (First, Middle, Las Joseph Teck				Mary S	ilverste		
and 2 sh	m 27 is m her traum		19a. Informant's Name/Relationship Patricia Elizabe	Daughter th Teck -	10537	MacArth	ur Blvd.	Potomac	r, City or Town, Sta	4
Saltimore,  ermit. Pages 1 ar  bepartment of Hea	Important: if item 27 is marked or eny injury or other traumatic eve once.		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	National Nation State	tional	osition (Name of matory or other place Cremator	y 09/0	7/2006	Falls Ch	urch, VA
Dermit Depar	eny in		21. Signature of Funeral Service Lice	Munay	5	130 Wisc	onsin Av	e NW Wasl	ler's Son hington,	DC 20016
	sician edical		23a. Part 1. Enter the disease or conshock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.  _aCereb	ral Vas	ter the mode of dyir		ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quance off;					
death death	y the attending pl ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3[	Ectopic pregnancy	,		23d. Date o Month	f delivery Day Year
Ords, P.O	been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	ren in Part I.			te to the cause of death?  Probably 4 Unknown
The law	ete hes page 2	Completed						24a. Was autop perfor 1 \( \text{Yes}	rmed? prio	re autopsy findings available r to completion of cause of th? Yes 2 \( \subseteq \) No
VICIAN: T	is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth		ath (Check only o		
UIVISION OF VITA To the Hospital or Attending Physician: within 24 hours efter death.	tor: After this the funeral di	ertification; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur	- 4 - Nursing		fence 6 Stother (	(Specify) HOSPICE
UIVISION tal or Attending 's efter death.	nerei Directo filled in by th	Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, sti ify)	reet, factory, office		28f. Location (S City or Tox	Street and Number o vn, State)	or Rural Route Number,
he Hospii n 24 hour	he Funere pletely fills	edicai	29a. Certifying F (Check only one)  Check only one)	Physician: To the best of my kn ammer: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and plac pinion, death occ	e, and due to the curred at the time, o	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
20		Σ	29b. Signature and title of certifier  Cypithia M	. William	s Do	29c. Licens	6 number 058 O.		29d. Date signed (A Sept	Month, Day, Year)
			30. Name an address of person who Cynthia M. Willi	ams DO /6001 M	uncaste	er Mill R	d. Rockv	ille, MD	20855	
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32 Registrar's Sign	ature Ap	este)				

			1 - For State Registrar Amend #26 pe	State of Marylan				Mental Hy	giene Reg. No.	2006	302	257
	Physicia	an	Decedent's Name (First, Middle, Last)	)		240		2. Date of De Month	ath Day	Year	3. Time of	
	/Medic Examin		Shirley Louise 4a. Facility Name (If not institution, give			4b. City, Town	or Location of Dea	Sept.	2 4c. (	2006 County of Deal	9:30_	A M
i dayir-	LXamiii	C1 . ,##	Kline Hospice Ho			Mount	Airy			Fred	lerick	
#	Funeral		Social Security Number 6. Sex			If Under 1 Year Months Day	r If Under 24 Hrs s Hours Min		th sy, Year)	9. Birt	hplace (State of	r Foreign
	Director		212-38-4595	69	Yrs.			July 2	3, 19	37 Mai	yland	
	land	}	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside Cit	ty Limits
	Mary If eh	to	Maryland Frederic	k	Frede	erick					1 ⊠ Yes	2 🗌 No
	or 28s	Directo	10e. Streel and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?	
	23a c	ral	1418-G Taney Ave	nue		21	702		U:	nited S	tates	
	er deg	Funeral		12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 1	<ol> <li>Race - Ame Black, White</li> </ol>		
36	irs aft	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 N	o Specify:			Specify: Wh	ite	
Ş	2 hou		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occ	upation	U. 11	16b. Kin	d of Business/	îndustry	
212	Par I	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work don DO NOT use reti	e during most of wo red)	orking				
7	ygien ygien rer th	Con		2	Оре	erator	1			Telepho	ne	
Maryland 21215-0036	be fill be fill be fill be fill be fill be of the better o	Be	17. Father's Name (First, Middle, Last)					ime (First, Middle		Sumame)		
Ž	should be filed within 72 hours after death with the Maryland and Menty Hygiene. In Menty Hygiene 1998 or 28a-f ehow marked other then "naturel", or teme 23a or 28a-f ehow umatic event, it a Medical Exercical must be redified at	ဥ	Guy O. Tressler  19a. Informant's Name/Relationship (Ty	une Print)	19h Mailir	o Address (Stra	et and Number or F	M. Morg		Town State 2	Zin Code)	
Σ	and 2 she ealth and n 27 is my		Eleanor Meyer / Si			Perry R		Airy, N	-			
dî.			20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of matory or other p	1	Date		ation - City or		
Ë	Page nent o int:#		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	nemoval from State		Cremato	ory Sep	tember 2006	Fred	erick,	Mary1ar	nd
Baltimore,	permit. Pages 1 Department of H Importent; If ite eny injury or oti onger.		21. Signature of Funeral Service License	ee/	22	2. Name and Add	ress of Facility St	auffer E	uner	al Home	s, P.A.	
11	20 E 2 9		1 X X	4			eville B1			y, Mary		
F	Physician		23a. Part1. Enter the diséase or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.			-	ac or respiratory a	rrest,		Approximate Interval Betv Onset and D	ween Death
-	/Medical Examiner		resulting in death)	a. Endonch Due to (or as a consequ	uence of):		CF					
		-	Sequentially list conditions,	bb. Due to (or as a consequence)	uence of):							
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):							
9/8	ate be hysici the bu	dlcal	L.	d								
ē ×	eath certific attending pl for use as t	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	nov							
POX	atten for us	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal	I death 3	Ectopic pregnar Other (specify)			2	3d. Date of del Month	,	rear
J.	by the ached	hysi	1 ☐ Yes 2√☐ No 9 ☐ Unknown	9☐ Unknown								
	iaw requires that the de as been signed by the a 2 should be detached i	ру Р	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause (	given in Part I.	23e. Did 1	obacco us	e contribute to	the cause of de	eath?
מ	w require been signal							1 🗆	Yes 2	Prio 3∏Pr	obably 4 □U	inknown
Ö	law r las be	Completed						24a. Was	psy	prior to	lopsy findings a	available ause of
	: The lav	Co						perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 🗆 No	
	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only o			Hosp	ice
	<u>a</u> = @	: To	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of	nt 3□ DOA   f 28c. ln	Other: 4 Nursing	Home - 5 Rose 28d. Describe			House	
<u>o</u>	nding ath. r: After e funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		lork? ∐Yes 2∐No					
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific		eel, factory, offic	8		Street and wn, State)	Number or Ru	iral Route Numb	ber,
5	ital or aft rail Di											
	Hospital 24 hours a Funeral stely filled	edical	29a. Certifier 1. Certifying Physical (Check only one) 2 Medical Examination (Check only one)	sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date	signed (Monti	h, Day, Year)	
)	- > - 0		Michael	Lerner		DY	1619		Sent	ten de	-5,2	2006
	10		30. Name and address of person who co	ompleted cause of death (Iten	n 23a) (Type,		,		4		•	
	`		michael Lernerm	5 63 Thomas	Johnx	n 12 51 no	RE Fred	wick m	21	70J,		
3 4	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	tture	meles						

State of Maryland / Department of Health and Mental Hydiene 2 0 0

			1 - State of State of Registrar		artment of Health ar <i>rtificate of Death</i>		eneZUU5	30258
3	100		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medic		Sarah Kathryn Ta	nsill		Septembe		4:00PM™
4	Examir		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or Location of [		4c. County of Death	
			Kline Hospice House  5. Social Security Number 6. Sex 7	Ago (In use last high day)	Mt. Airy If Under 1 Year If Under 24		Frederi	
	Funeral Director		215-42-8327  Usual Residence of Decedent	. Age (In yrs. last birthday) 87 Yrs.		Min. 8. Date of Birth (Month, Day, ) Feb. 12,	1919 West	lace (State or Foreign htry) : Virginia
	land •		10a. State 10b. County	10c. City, Town or Lo	ocation		1	Od. Inside City Limits
	Mary Figure	tor	Maryland Frederick		Frederick			1 X Yes 2 □ No
	h the	irec	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Coun	itry?
	23a c	alD	1421 Taney Ave., Apt. 20	06	21702		U.S.A.	
	er dea	unei	Armed Ford	ent Ever in U.S. 13.1	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinational be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1 Yes, 2 If Yes, Give Year or Dat	2 <b>X</b> No	1 ☐ Yes 2 🗷 No Specify:		Specify: Wh	ite
5-0	72 h natu	etec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most or	f working	6b. Kind of Business/Ind	dustry
121	within ane. then	mp	Elementary/Secondary (0-12) College (1-	for 5+)	DO NOT use retired)			
	filed Hygie ther		17. Father's Name (First, Middle, Last)			Name (First, Middle, Ma		pt. store
an	ld be ental ked o	To Be	Lewis Baxter Bonnett			cretia Benne		
Maryland	2 should be and Mental I is marked or aumatic eve	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number of			Code)
	and 2 ealth a n 27 ls		Nancy C. Kline/ daughter	9710	Clydeleven Dr.	. Hagersto	own, MD 217	40
ore	of He of He fiten		20a. Method of Disposition 1 □ Burial 2 🖔 Cremation 3 □ Removal from S	20b. Place of Dispo			Oc. Location - City or To	
Ĕ	Pages ment of ant: If it		4 Donation 5 Other (Specify)	All Count	y Cremation 9,	/12/2006	Sykesville	, MD
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once.		21. Signature of Funeral Service Licensee	1// / .	Name and Address of Facility O4 S. Main St.		uneral Home o, MD 21798	
.34			23a. Part1. Enter the disease, or complications that cashock, or heart failure. List only one cause on ea	sed the death. Do not ent	er the mode of dying, such as ca	rdiac or respiratory arres	it,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Killada	Lailus			Onset and Death
	/Medical		resulting in death)	r as a consequence of):	2 1 211 01			1 001
	Examiner	_	Sequentially list conditions, b	Nybe/	Hasion			VENIC
	pe isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as á consequence of):	V		ŀ	7
	and and II-tran	хап	that initiated events C.	r as a consequence of):				1
68760,	sician buris						110	
89	ificate g phy as the	edical	U					
O. Box	To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 moeths?	nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
٦	signed b	by Pł	Part ff. Other significant conditions contributing to dea	th but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
Records,	w require been sig should b	ed b	Athurotalprotic	- HUACT	) lease	1 ☐ Yes	No 3□ Prob	ably 4 ∐Unknown
၁၁	aw re ss bee 2 sho	Completed	Sac Flore Cal V	a contac	Disease	24a. Was an	24b. Were autor	osy findings available
B.	sician: The law certificate has b irector, page 2 s	Com	Dell'intial V	7001700	91700	autopsy performe	od? death?	npletion of cause of 2 \subseteq No
Vital	cian: ertifica	Be	25. Was case referred to medicat examiner?		26. Place of	Death (Check only one)	^	27.00
of \	hysic this co	Lo	1 ☐ Yes No Hospital: 1 ☐ In	patient 2 ER/Outpatien		ng Home 5 Residence		tonse
n C	ling F	ion:	Talulai Sureliding	Injury 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
Division	Attendideath. ctor: A y the fu	icat	Accident investigation  3 ☐ Suicide 6 ☐ Could not be 280 Place 6	f Injury - At home, farm, str	M 1 Yes 2 No		et and Number or Rura	I Double Mumber
Ď	after Direct	Certification:	4 Homicide determined 200. Place of building	, etc. (Specify)	eet, ractory, office	City or Town,		n moute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the b	est of my knowledge, death	n occurred at the time, date and p	place, and due to the cau	se(s) and manner as st	ated.
	n 24 h	Medical	(Check only 2 Medical Examiner: On the bas one) and manne	is of examination and/or inv	vestigation, in my opinion, death	occurred at the time, date	e and place, and due to	the cause(s)
	To the To the Comp	Ž	29b. Signature and tyle of certifier	/1// -	29c. License number	290	I. Date signed (Month, I	Day, Year)
	WJL		MANIA	1	-M/2/)/	042X	911119	)(0
	4		30. Name and address of person who completed cause			1 115 04-0		X
75			Casper E. Cl/Ine III  31. Date filed (Month, Day, Year)  32. Rev		th St., Frederi	ck, MD 21/0	1,1 (	
	Sta Registr		SEP 1 1 2006	trar's Signature	Search .			
			0 m1 m m m000		1			

attending physician a for use as the burialsigned by t this certificate To the Hospital or Attending Physician: After hours after death. within 24 hours after death To tha Funeral Diractor:

Itams 23s or 28a-f show

27 Is marked other than "nature traumatic event, the Medical

filed within 72 hours after death with

Pages 1 and 2 should be finent of Health and Mental F

Baltimore, Maryland 21215-0036

BA 10+1

31. Date filed (Month, Day, Year) SEP 1 1 2006 Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUD OLD DEETH CITY 32. Degistrar's Signature

Beruin, MD Edwin T. Castaneda, M.D.

12006

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

	1. Decedent's Name (First, Middle, Las	Trbi (MH	Certificate of Death	Reg. 2. Date of Death		3. Time of Death
an al	Eduardus Antoniu	us van Rossum			Day Year 3, 2006	4:35 p M
er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat		4c. County of Death	
	103 Lahinch Driv		Millersvill  (day) If Under 1 Year   If Under 24 Hrs		Anne A	
		DATA SOLE	rs. Months Days Hours Min.	Jan. 30,	1952 Box	place (State or Foreign intry) tel, Hollar
	Usual Residence of Decedent			Joans 30,	1000	
7	10a. State 10b. County  MD Anne A	10c. City, Town				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Director	10e. Street and Number	ranaer	Millersville	100.	Citizen of What Cou	
	103 Lahinch Driv	<i>v</i> e	21108		USA	-
Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S tf Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Ameri Black, White	
by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2X No Specify:	0.00.7	Specify: Whi	
	3 Widowed 4 Divorced	Year or Dates:	Decedent's Usual Occupation	161	o. Kind of Business/li	
Completed	(Specify only highest grad	de completed) (	Give kind of work done during most of wo life. DO NOT use retired)	rkina	Commercial	•
ĕ	Elementary/Secondary (0-12)	4	Regional Manager		roducts (	
Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai	den Surname)	
၉	Petrus van Rossu			da Kupers		
	19a. Informant's Name/Relationship (7 Dawn Marie van F		Mailing Address (Street and Number or Ri 03 Labinch Drive, Mi			
	20a. Method of Disposition	20b. Place of I	Disposition (Name of	Date 20d	c. Location - City or T	
	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Mondor	ridge Cemetery Sep	. 8, 2006 E	lkridge,	MD
	21. Signature of Funeral Service Licen	·	22. Name and Address of Facility	Tiles -	Anna Land Land	
	Comes El	Uh	Barranco & Sons, P 495 Gov. Ritchie H	wy, Severn	a Park, M	pera 1146 me
	23a. Part1 Enter the disease, or comp shock, or heart failure. List only		ot enter the mode of dying, such as cardia	or respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	a	melanoma			Onset and Death
	resulting in death)	Due to (or as a consequence of				1/2 13
er	Sequentially list conditions,	b. Due to (or as a consequence of	).			
Ĕ	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		•			
Examin	resulting in death) Last	Due to (or as a consequence of	):			
cal		d				
Med	IF FEMALE:	00-14				
Physician/Medic	in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	rery Day Year
ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	3 🗆 Other (specify)			
by P	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
	, i			1 🗆 Yes	2 □ No 3 □ Pro	bably 4 <u>□</u> Unknow
piet				24a. Was an autopsy	24b. Were aut	opsy findings available
Completed				performed	death?	
ø	25. Was case referred to medical examiner?	Ha saite li		ath (Check only one)		
D	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Tir		lome 5 Residence		ify)
ို	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Inj	me of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. Describe now i	injury occurred	
٥	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm	π, street, factory, office	28f. Location (Stree	t and Number or Rur	al Route Number,
ို	4 [] Hornicide	building, etc. (Specity)		City or Town, S	(ate)	
ို		ysician: To the best of my knowledge,	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the caus	e(s) and manner as	stated.
Certification: To	(Check only 2 Medical Exam				Date signed (Month,	
edicai Certification: To	(Check only 2 Medical Examone)	and manner stated.	20c Licence number		Date signed (Month,	, Day, rear)
edicai Certification: To	(Check only 2 Medical Exam	and manner stated.	29c. License number	255.	91412.00	26
Certification: T	(Check only 2 Medical Examone)  29b. Signature and title of certifier	nich aus	D19838		9/4/200	06
edical Certification: To	(Check only 2 Medical Examone)  29b. Signature and title of certifier  30. Name ind address of person who describes the second of the second o	completed cause of death (Item 23a) (TOUCK MD 90)	D19838	Annap	9/4/200	06 Ud. 2140

Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 30261 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** September 9, 2006 Veronique NMN VILLALTA 17:23 p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 334 South Locust Street Hagerstown Washington Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 15,1977 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗓 F 127-60-7216 Yrs. 29 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b County 10a State 10d. Inside City Limits 1XXYes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 334 South Locust Street 238 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1₺Yes 2□No Specify:Puerto Rican Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Hispanic Hondurian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 - 8none O none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Otto Sergio Villalta Yolanda NMN ပ Valentin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Deportment of Health ar Important: if Item 27 ts any njury or other trau Otto S. Villalta - father 334 South Locust Street, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hagerstown Crematory 9/12/06 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Salux 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asphyxia tositional **Physician** /Medical Due to (or as a consequence of): Examiner 75 5 Obesit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably → Unknown 1 ☐ Yes 2 ☐ No DISGUSR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No Asthmor 1 ☐ Yes 1 Tes 2□ No : After this certifical funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner?
1 Xes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) )ma, 0056965 Dm 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steple Kotcl
31. Date filed (Month, Day, Year) MO 125 C. Antiet Stiert 32. Registrar's Signature State 1 2 2006 Registrar

6-06908		Pleas	e Type or Print in	В	lack Indel	ible In	ık						
Deborah Elizabeth V	Vorsham S	tate of Maryla	and / Department of	of I	Health and	Menta	al Hy	giene					
	1- For State Registrar		Certificate of	of L	Death			Reg I	No. 2	$\Omega$	6 30	26	2
Physician/	1. Decedent's Name (First, Midd	fle,Last)					:	<ol> <li>Date of Death Month Date</li> </ol>	y Year		3. Time of Death	_ 7	-
Medical Examiner	Deborah E	. Worsham	m					September 1	3, 2006		0705 hrs		
Sam Nove .	4a. Facility Name (if not instituti	on, give street and nu	ımber)	4b	. City, Town, or L	ocation of	Death		4c. County of	f Death			
	10111 Watkins Mill P	lace			Montgomery	Village			Montgom	nery			
Funeral	5 Social Security Number	6 Sex	7 Age (In yrs. last birthday)		If Under 1 Year	If Under	24Hrs.	8. Date of Birth (N	,				
Director	212-78-0012	1 M 2 X F	47 Y		Months Days	Hours	Min.	Feb. 15	5, 1959	Foreigr	ntry) MD		

		Registrar				runcate	- 01	Dealli					eg No.	_20		6 3020
Physicia Medical Exami	1111/	1. Decedent's Name (First, I										. Date of Dea Month Septembe		Year	3	0705 hrs
	ilei	Deborah  4a. Facility Name (if not inst	E .	Worsha			14	b. City, To	wn. or Lo	ocation of		Septembe		County of De	eath	
		10111 Watkins Mi		o on oor and m	uii,50.,		-   '			Village			1	/lontgomer		
Funeral		5 Social Security Number	6 S	ex	7 Age (In yrs.	last birthday	<u>,                                     </u>	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	rth (MM/	DD/YYYY) 9		place (State or
Director		212-78-0012	1	M 2 X F	47		Yrs.	Months	Days	Hours	Min.	Feb.	15,	1959 <sup>Fo</sup>	reign Coun	try) MD
	ŀ	Usual Residence of Decede		JL.J.	l									<u>-</u>	-	
any		10a State 10b. Co.	•		10c. City	, Town or L				_					- 1	0d Inside City Limits
nd show	칟	MD Mo	ntgon	nery		Mon	tgo	mery	Vil	lage						Yes 2 X No
faryla 28a-f	Director	10e. Street and Number			<del>'</del>			10f. Zip (	Code			1	0g. Citi	zen of What C	ountr	λs
th the Maryland 23a or 28a-f show any notified at once.		10111Watki	ns Mi	111 Pla	ce				2088	6			Uı	nited S	Sta	tes
5-0036 led within 72 hours after death with the Maryland tygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status	7	A 4 5	cedent Ever in U	J.S 13		Deceden				cify Yes or No	)-	14. Race - An		n Indian, Black,
deatl or ite	اج	1 Never Married 2	_	1 Yes	2 X No						T GOTTO TT	10011, 010.)		VVIIIC, DI		
s after ral",	ā	3 X Widowed 4		If Yes, Give Ye or Dates.		1		Yes 2				l dese	Iach t	Specify.		hite
5-0036 led within 72 hours tygiene other than "natur	fe	15. Decedent's Education  Elementary/Secondary (0)			1-4 or 5+)			's Usual 0 st of work					100. F	Kind of Busine	SS/INC	ustry
36 iin 72 ihan 'dical	Completed	Elementary/Secondary (C	-12)	1	1-4 01 3+)	Docu	mer	t Co	ntro	1 Sp	ecia	list	1	Enginee	ri	ng
-00 d with giene ther t	ĕ	17. Father's Name (First, M	ddle, Last			] Docu.						irst, Middle,				
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	Stanley Le								Shir	ley A	Ann Tr	ages	ser		
21215-0036 hould be filed within 72 hours a nd Mental Hygiene is marked other than "natura atte event, the Medical Examin	To	19a Informant's Name/Rela				19b. M	ailing	Address	(Street	and Numb	ber or Rui	ral Route Nur	mber, C	ity or Town, St	ate, Z	ip Code)
2 2 s 2 2 s 2 2 2 2 2 2 2 2 2 2 2 2 2 2	11	Christopher	Pecha	acek/ S	on	22 1	Voc	dtri	dge	Stre	et,	Cambri	dge	, MA 02	214	0
ore, Nest and of Health If item		20a. Method of Disposition	-13 0			Place of Di crematory			e of ceme	etery,		Date	20c.	Location - City	or To	wn, State
TOT Pages ent of int: 14		1 X Burial 2 Crem 4 Donation 5 Oth			Par	klawn			al.		Şept	ember 2006	l R	ockvi1	1e.	MD
Baltimore, sernit. Pages I ar Department of Hee important: If ite injury or other tr	Ηů	21. Signature of Funeral Se					22. <b>N</b>	ame and A	ddress o	of Facility						10 East
<b>小</b> 员 图显显显	5 V	TRACY A.	itu	rc							, Ga	ithers	burg	g, MD 2	-	
Physician		23a. Part I. Enter the diseas failure. List only one of			caused the deat	h. Do not er	ter th	e mode of	dying, s	uch as ca	ardiac or r	espiratory arr	est, sho	ock, or heart		Approximate Interval Between Onset and
/Medical	5 4	Immediate Cause (Final dis			and Neck	Injuri	es								8	Death
.xammer		or condition resulting in dea	th)	Due to (or as	a consequence	of):									1	
¥.,	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b		a consequence	of):									+	
	Examiner	cause. Enter Underlying C	use		a consequence	017.					474			20.0		
p :10	xar	(Disease or injury that initial events resulting in death). I		Due to (or as	a consequence	of):										
ecute and - tran:			<b>—</b> d												-	
760, cate be execut physician and he burial - tral	an/Medical	XUNPENDED	-	AMENDED	ILEII#Z		3a-:	f,perM	E,g85	9,9/2	6/06 '	TT				
68760, sertificate be tiding physicise as the buri	Ň	IF FEMALE: 23b. Was decedent pregnan	in the	23c If yes,	outcome of pre	gnancy 2	Fet	al death	3	Ectopic	pregnano	cv.	230	d Date of deli Month	very Da	Year
certi certin	ciar	past 12 months?			nant at time of o		-	er (Speci		Lotopio	program	-3		WOTE	Du	, iou
Box e death c the atten	Physici	1 Yes 2 No 9	Unknow	9 Unkr	nown											
P.O. Box 685 s. that the death certifi gned by the attending e detached for use as it	<u>۲</u>	Part II. Other significant c	nditions	contributing	to death but not	resulting in	the u	nderlying (	cause giv	ven in Par	rt I.			_		e cause of death?
ires that signed	d by											1Ye	s 2 🗸	No 3 F	Probal	oly 4 Unknown
ords.	Completed											24a Was autor				osy findings available inpletion of cause of
Reco The law icate has	шc											perfo 1 ✓ Yes	rmed?	death		2 No
tal Re( iam: The certificate	Ö	25. Was case referred to m	edical					2			Check on	ly one)		-		
Division of Vital Records, tat or Attending Physician: The law requires after death all Director: After this certificate has been seled in by the funeral director, page 2 should be	o B	examiner?		Hospital: 1	Inpatient 2	ER/Outpa	itient	3 DO	OA C	other4	Nursing	Home 5	Reside	ence 6 🗸 O	ther S	Scene
1 of \langle ling Phy	ı.	27. Manner of Death		28a Date	e of Injury	28b Time	e of Ir	njury 28	Bc Injury	at Work?	? 2	8d. Describe	how inju	ury occurred		
ion tendin eath lor: /	atio	1 Natural 5 2 X Accident	Pending Investigat	Fnd	9/13/2006	Fnd 6	<b>5:5</b> 0	am	1 Ye	es 2 X	No	subject	fel	lfrom st	air	S
IVISION or Attentative death	iţi	3 Suicide 6	Could no	be 28e. Pla	ce of Injury - At	home, farm,	stree	t, factory,	office bu	iilding, etc	2	8f. Location (	Street a			Route Number, City
Division Hospital or Atten 24 hours after death Funeral Director: tely filled in by the	Certification:	4 Homicide	determine	ed (Specify	reside	ence					1	Montgame	ery V	illage,	MD	
		(Oncor only			est of my knowle											
To the Hos within 24 h To the Fur completely	Medical	2		er: On the basis and manner	of examination stated	and/of inve	sugati				Jurred at t	ne ume, date				
_ K	Σ	29b. Signature and title of c	2					29c	License					Date signed (		
		my	ر ند	mis					O.C.N	1. E.			Sep	otember 14	, 200	ou
		30. Name and address of p					·	+ D=141-	2055	AD 242	01					
			istant N	Medical Exa		1 Penn S	uree	ı, baitin	iore, N	110 2 12	U I					
s	tate	31. Date filed (Month Day)	1°9	2006 32	egistrar's Signa	iure	108	de								

State of Maryland / Department of Health and Mental Hygiene 2006 30263 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** September 2 2006 Lillian Catherine Walker 0915 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 550 Coover Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 30 1911 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 95 Yrs. Massachusetts Director 010-09-2505 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Mode r 28a-f show 1 ☐ Yes 2 🙀 No Director Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ma 23a or 550 Coover Road 21401 USA Funeral ir than "natural", or itama the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural; or Itan any injury or other traumatic avant, the Medical Examinations. Black, White, etc. 1XX es 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Yes, Give Specify: Specify: White ٥ 3 Widowed 4 □ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Morris Fitzgerald Mary Martin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph A. Walker, Jr. (Son) 550 Coover Road, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-5-2006 Metro Crematory Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 77 2. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician PREdumende Myscondine IN BALL DID resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 4 Bunknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate PERTEDUION 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 2 ER/Outpatient 3□ DOA ŧ 27. Manuar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. i Diractor: A d in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Scotziser 5 2006 023157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 Anthony Caputo, MD 139 Old Solomons Island Road, Annapolis, MD 21401

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 30264 1- State Registrar Amend #1 per Phys/FH 09-08-2096ificate of Death CNM Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 16:30 PM Bryon Timothy West SEPH 04 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner AltiMORE UNIVERSITY 04 N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Pay, Year)
June 20, 1961 Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1G M 2□ F 218-74-0515 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other then "neturel", or items 23a or 28a-1 show or other treumatic event, the Medical Examinar must be notified at 1 Tyres 2 □ No Directo Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 U.S.A. 9 Tacoma Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. permit. Pages 1 and 2 should be filled within 72 hours effer a Deperment of Health and Mental Hygiene. Important: if item 27 le marked other then "neturel", or item eny lajury or other treumatic event, the Medical Examines PAGE. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent F.O. Day Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Leroy West Norma Brice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Tacoma Street, Thurmont, MD 21788 19a. Informant's Name/Relationship (Type, Print) Donna M. West / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Blue Ridge Cemetery 9/9/06 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROBERT E. DAILEY & SON FUNERAL HOMES, P. 615 EAST MAIN STREET, THURMONT, MD 21788 oles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death CLOSED HEAD Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): NO EVANITER Examiner ending physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 3d. Date of delivery 23b. Was decedent pregnant CERTIF 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate hes b director, page 2 s autopsy performed? 1 ☐ Yes 2 2 No To the Hospital or Attending Physicien: lilled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1⊈ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending 2205 death. -06 М 1 ☐ Yes 2 🕱 No investigation -02 TERRAIN VEhiCLE 2 Accident 24 hours after deat • Funeret Director: 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) RF 806 NEAR HEILY'S STERE R Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide STREET 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 91716 384 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S+ BAlto M.D 22 + EV Ent S GREEN sistrar's Signature State Registrar

			1 - For State Registrar		State o	f Marylai	nd / Depa <i>Ce</i> a	artme <i>rtifica</i>	nt of H te of L	ealth a D <i>eath</i>	and M	lental Hy	gien Reg. Ne		06	3028	5
	Physici /Medi		1. Decedent's Name (First, Mi	leave:	r							2. Date of De Month Septen	nber			3. Time of Death	М .
	Examir Funeral Director	er	4a. Facility Name (If not institute Washington Cout 5. Social Security Number 204-01-9562	inty 6. Sex	Hospita	al	. last birthday) 88 Yrs.	Hag	ersto er 1 Year	Wn If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Di	rth ay, Year	ashin	g tor Birthp Coun	lace (State or Forei try)	gn
	ס		Usual Residence of Decedent  10a. State  10b. Cou	nty		10c. C	ity, Town or Lo	ocation				November	UL,	917		PA Od. Inside City Limit	
	vith the Ma or 28a-f	Director	MD Wash	ingto	on		Hancoc		ip Code	·-·-·			10g. C	itizen of Wh	at Coun	1 X Yes 2 □ N try?	0
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Exporter marke notified at	by Funeral	118 Washingt  11. Marital Status  1 □ Never Married 2 □ M  3 ☑ Widowed 4 □ Divord	arried		2 No		Was Dec	ecify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		ISA 14. Race - Black, Specify:	White,		
Maryland 21215-0036	nd within 72 ho giene. er then *natur: . Ine Medicel i	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1) 12			-4or 5+)	16a. Deced (Give life. Assem	kind of w DO NOT	rork done o use retired	furina most	of worki	ng		Gind of Busin		ufacture	
ryland	should be filed ind Mental Hygie marked other umatic event, III	To Be C	17. Father's Name (First, Midd Wilbur B. W	eave			19h Mailir	a Addre	ss /Street a	Est	her	(First, Middle Nichol:	son		ate Zio	Code	
a,	Pages 1 and 2 s nent of Heelth ar int: If Item 27 is iry or other trau		Linda K. McCar 20a. Method of Disposition 1 \ Burial 2 Crematic	ty/Da	aughter	20b. State	13808 Place of Dispo cemetery, crer	Ex1:	ine Re ame of other place	oad H	anco	ck, MD	217 20c. L	50 ocation - Ci	ty or To		
Baltin	permit. Pages Department of t Important: If It any injury or o		4 Donation 5 Other 21. Signature of Juneral Serv			St		2. Name a	and Addres	s of Facility	1	/06 41 Wes P.A. Ha	t Ma	in St	reet	'50 <b>-</b> 0368	
	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or compli ist only or	ACL	ach line.	Ith. Do not ent	er the mo	ode of dying	g, such as o	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death	
8760,	cate be executed (2) physicien and (1) the burial-transit (2)	dical Examiner	Saturationly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		DU® to (	or as a conse	TI U7U quence of):										
P.O. Box 6	death certifi e attending I d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	1☐Live bi	come of pregnith 2 Feti ant at time of own	al death 3	Ectopic   Other (s	oregnancy specify)					23d. Date of Month		ry Day Year	
rds, P	w requires that the de been signed by the a should be detached i	þ	Part II. Other significant cond ULINARY TRACT						-	n in Part I.						e cause of death?	n
Vital Records,	The law ate has b page 2 s	Completed	PULMONARY PIS		£							24a. Was auto perio 1 🗆 Yes		prio	r to com	sy findings available pletion of cause of No	е
ō	ding Phy th. After this funeral d	tlon: To Be	25. Was case referred to med examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pen 2 Accident inve	Н	+	npatient 2 [ of Injury h, Day Year)	ER/Outpatien 28b. Time of Injury		28c. Injury Work	t: 4 ☐ Nur	sing Hon	Check only one 5 Resi	dence		Specify,	)	
	2 4 4	Certification:	3 ☐ Suicide 6 ☐ Cou	-	28e. Place buildir	of Injury - At h ng, etc. (Speci	nome, farm, stri	eet, facto				28f. Location ( City or To	Street ar wn, State	nd Number (	or Rural	Route Number,	
	To the Hospital can within 24 hours at the Funerel D completely filled in	edical	29a. Certifier 1 Certification (Check only one)	ing Phys al Examir	sician: To the ner: On the ba and mann	isis of examin	owledge, death ation and/or inv	occurre vestigatio	d at the tim n, in my op	e, date and inion, death	place, a	ind due to the ad at the time,	cause(s date and	) and mann d place, and	er as sta I due to	ated. the cause(s)	
ŕ	P No I	≥	29b. Signature and title of cert  Machour	HW				1	0c. License 06.25	62				te signed (/		lool.	
Ś			30. Name and address of pers  WASHINGTON	coun	ity Hos	PITAL	251 € 1	Print) /	MADH	AVI I	ect	HAGE	とらてひ	w/ m	ARY	LAMDZITHE	,
	Sta Registr	_	31. Date filed (Month, Day, Ye SEP	222	006	entrar's Sign	dt.	bou									

State of Maryland / Department of Health and Mental Hygiene 2006 30266 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 6, 2006 **Physician** Fortunate YEDLIN 10:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13008 Autumn Drive Silver Spring Montgomery 8. Date of Birth June 17, Year 921 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 212-54-7275 1 □ M 2 🖾 F 85 Egypt Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 N No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13008 Autumn Drive 20904 United States by Funeral death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F eq pinous Victor Cesana Esperosa Nacson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Heeith ar Heeith Hem 27 Joseph Yedlin, Husband 13008 Autumn Drive, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any injury or ponce. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lebanon Cemetery | 09/07/06 Adelphi, MD 21. Signature of Fun fall September Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012
Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner 40 Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-translt death certificate be executed Bifascicular Heart Block 10 Years Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 217 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by or A 4 - Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 005184 09/06/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Leonard Glenn, M.D., 12520 Prosperity Dr., #150, Silver Spring, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State - 8 2006 Registrar

			For State Registrar	State of	Maryland /		artment rtificate			and Me		iene 2	006	30267
	Physici		1. Decedent's Name (First, Middle Rachel Mary Ja		and						2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution				4b. City, To	own, or	Location o	of Death		-	unty of Death	6.00M
	LAdillii		15 Bayside Dr	ive			Nor						ecil	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last b	irthday)	If Under 1		If Under 2	24 Hrs. Min.	B. Date of Birth (Month, Day)	1		place (State or Foreign
L	Director		216-34-8004	1 □ M 2 ဩ F	69	Yrs.	Worldis	Days	riodis		une 23			Ridge, MD
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation							10d. Inside City Limits
	Maryl f sho	ō		1										1 □ Yes 2 ₩ No
	the rough	rect	Maryland Ceci 10e. Street and Number	.1	North	Eas	10f. Zip C	Code			1	0g. Citizen	of What Cou	ntry?
	h with	Funeral Director	15 Bayside Dri	ve			2190	0.1			Т	Inited	l State	26
	ems ?	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13.			spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	14.	Race - Ameri Black, White.	can Indian,
36	or It	y Fu	1 Never Married 2 Marr	ied 1 Tyes 2:	<b>⊠</b> No		1 □ Yes 2√		Specify:	, 1 00:10 11	ioan, etc.)			
Ö	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Medical Examinar must be notified at	ed by	3 ₩idowed 4 □ Divorced								1		***	nite
5	in 72 "na" r	Completed	(Specify only highes	st grade completed)		(Give	dent's Usual kind of work DO NOT use	done a	ation <i>Juring m</i> ost )	of working	9	160. Kind	of Business/In	idustry
212	i with jiene. r thau	mo	Elementary/Secondary (0-12)	College (1-4	or 5+)	Ca	regive	21				Host	nice	
힏	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle,	Last)					18. Mother	r's Name	First, Middle, I			
<u>a</u>	ould b Menta arked	To E	Elmer Miller						Haz	zel C	ooper			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relations	hip (Type, Print)	19	b. Mailir	ng Address (	Street a	and Numbe	r or Rural	Route Number	City or To		Code) 21914
e)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		Darry 1 R. Young	blood/Son_	20h Place	O.	Box 38	3 4	6 Car	rpent	er's Po	int I	Char	lestown, MD
Baltimore,	ages to to to the or of		1 Burial 2 Cremation	3 □Removal from Sta	ate Cemete	өгу, сгөг	natory or oth	er piace	9)					
₽	iit. Partmer artmer ortant injury		'4 ☐ Donation 5 ☐ Other (S		North		st Met				13,2006			MD
Ba	Departimbe		VIIII I	The state of						0-	ouch Fu			yland 21901
	18/		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do								ic, Hai	Approximate
	Pnysician		Immediate Cause (Final disease or condition	only one caus s or eac	raco	(	den		01					Interval Between Onset and Death
	/Medical		resulting in death)	aDue to (or	as a consequence	e of):		_						x man Ins
£.	Examiner		Sequentially list conditions.	b										
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	of):								
	xecute and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or	as a consequence	of):								
8760,	death certificate be executed e attending physician and od for use as the burial-transit				,								:	
.89	ificate g phy as the	edical		0.										
Вох	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnancy n 2 - Fetal deat	h 3	Ectopic pred	202001				23d.	Date of delive	ery
	ne deat the att	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death		Other (spec				<del>.</del>		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown											
	နှ တို့ ရ	by	Part II. Other significant condition	ons contributing to deat	n but not resulting	in the u	nderlying cau	ise give	en in Part I.		230. Did tot			he cause of death?  bably 4 □Unknown
Vital Records,	w requir been si should	Completed									-			
Rec	has ge 2 :	mp									24a. Was a autops perforn	у _	prior to co death?	ppsy findings available mpletion of cause of
G		e Co	25. Was case referred to medical						OC Disease	of Dooth		No	1 🗆 Yes	2 <del>□ No</del>
	Attending Physician: r death. ector: After this certific by the funeral director.	O B	examiner?	Hospital:	atient 2 ☐ ER/O	utpatier	nt 3□ DOA	Othe			Check only on		Other (Specif	(v)
סר	ding Ph h. After thi funeral	T:u	27. Manner of Death	28a. Date of I	njury 28b.	Time of		c. Injury Work		_	d. Describe ho			,,,
<u>0</u>	tending Ph Jeath. tor: After th the funeral	atlo	1 Natural 5 Pendin 2 Accident Investig	gation		,,	М		res 2□N	No				
Division of	l or Attendate after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could ( 4 ☐ Homicide determ	ined 286. Place of	Injury - At home, f , etc. (Specify)	arm, str	eet, factory,	office		28	If. Location (St. City or Town		umber or Rura	al Route Number,
	pital		29a. Certifier	a Physician: To the he	act of my knowledge	o dosti		Ale as Aires		1,000,00				
	24 hos 24 hos Fun etely	edical	(Check only 2 Medicel one)	g Physician: To the be Exeminer: On the basis and manner	s of examination a	nd/or in	vestigation, in	n my op	ie, date and pinion, deat	n place, and h occurred	d due to the ca I at the time, da	ause(s) and ate and pla	manner as si ce, and due to	tated. the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifie	-			29c. l	License	number		2:	9d. Date si	ned (Month,	Day, Year)
ŧ			lox =	)		M	DI	V	ns	64	49	9	8/0	6
	6		39. Name and address of person	who completed cause of	of death (Item 23a)	(Type,	Print) / /		ام	0	112		-11/1	110 01 = 1
		- 1	Gloria Dim	onson	WD III	W	25t H	righ	St.	Dui	te Sl	12 t	1Kton	MI) 2192
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	head	e)	1						1
	ricgisti	21	SFP 1 1 20	Jb Mayle	15 19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

			1 - For State Registrar AMEND#10eperFH	9/9/06,BMW,McCo	Cei	rtifica	te of Dea	ath	2. Date of Dea	Reg. No.		3 U Z D (
	Physic		Beverly Markman	Zitelman					9/4/200	Day	Year	8:50 P <sup>M</sup>
)	/Medi Examîr		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or Loca	tion of Death	37 1720		County of Death	0.50 1
			Suburban Hospital			]	Bethesda	L		1	Montgome	erv
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Und	er 1 Year   If U	nder 24 Hrs.	8. Date of Birt (Month, Day			place (State or Foreign
	Director		220-05-8706  Usual Residence of Decedent	]M 20XF 84	Yrs.	Month	s Days Ho	urs Min.	2/20/1	922_	Coui	MD
	Maryian I-f show	tor	10a. State 10b. County  MD Montgon		City, Town or Lo		-				1	0d. Inside City Limits  N☐ Yes 2 ☐ No
	7.282	<u>s</u>	10e. Street and Number		Deciret		ip Code			10g. Citiz	en of What Cour	ntry?
	38 o	0	5809 Nicholson Lar	1e, #4644			208	52		IJı	nited St	ates
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturs!', or Items 23a or 28a-f show simply or other traumatic event, Ita Medical Examinar must be notified at ODGs.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			edent of Hispani ecify Cuban, Me 2X No Spe	c Origin? (Spexican, Puerto	ecify Yes or No- Rican, etc.)	1-	4. Race - Americ Black, White, Specify:	can Indian,
Ď.	72 ho	Completed	15. Decedent's Edu		16a. Dece	dent's Us	ual Occupation	mant of words		16b. Kin	d of Business/In	dustry
7	thin 7	ed d	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	rork done during use retired)	most of work	ing			
7	gien gien	Ö	12	,	Hon	nemal	ter			(	Own Home	
פ	offile offy	Be (	17. Father's Name (First, Middle, Last)				18. M	dother's Name	(First, Middle,	Maiden S	Sumame)	
ā	Aents Aents rked	To	Simon Markman				S	arah C	haideke.	1		
, Maryland 21215-0036	alth and P		19a Informant's Name/Relationship (Ty, Marc Zitelman —Sor				ss (Street and No twright				Town, State, Zip 20878	Code)
Baltimore,	Pages 1 and of He int: If item		20a. Method of Disposition 1X Burial 2 □ Cremation 3 X B 4 □ Donation 5 □ Other (Specify)	emoval from State Ki	Place of Dispo cemetery, cree ng Davi	sition (N natory of d Me	ame of cother place morial	9/6	) oate 		ation · City or To S Church	
Balt	permit. Depertrimports sny inju		21. Signature of Funeral Service License		Da	Name a	and Address of F	dberg	Memoria:	l Cha	apels In 1D 20852	.C •
68760,	Artificate be executed and //Medical be executed and physicien and as the burdal-transit	Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. METAST  Due to (or as a conse	equence of):		de of dying, suci		or respiratory and	rest,		Approximate Interval Between Onset and Death O
P.O. Box 68	The law requires that the death certific sie has been signed by the attending p page 2 should be delached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 22 No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tel death 3□	]Ectopic ] Other (s	pregnancy specify)			23	d. Date of delive	ory Day Year
	uires that signed b lid be deta	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying	cause given in P	Part I.		bacco use		e cause of death?
Division of Vital Records,	sician: The law rec certificete has bee lirector, page 2 shou	Completed							24a. Was a autop: perfor	sy	24b. Were autoprior to condeath?	psy findings available inpletion of cause of
<u>E</u>	intifical stor, I	Bec	25. Was case referred to medical				26. P	Place of Death	Check only or			
<b>&gt;</b>	ysici is ce direc	ToE	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 🗆 C	Othor				Other (Specify	1
o uo	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes	2	28d. Describe h			,
DIVIS	P H S	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injury - At building, etc. (Spec	home, farm, stre	eet, facto	ry, office		28f. Location (S City or Town		Number or Rura	l Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurre restigatio	d at the time, date n, in my opinion,	e and place, a death occurre	and due to the c ed at the time, d	ause(s) a late and p	nd manner as st lace, and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			25	c. License numb		12	9d. Date	signed (Month, I	Day, Year)
)	(D)		//Mon + Myrum				D23302	8		9/	6/06	
			30. Name and address of person who con VICTOR M. PRIECO, MD	mpleted cause of death (Ite			4100 R	ENTES	OA, MO		<u> </u>	
	Sta Registr		31. Date filed (Month, Day, Year)  SEP - 8 20	32 Registrar's Sign	nature do	whi	)		, , , , , , ,			

	-	For State Registrar		Department of Health a Certificate of Death	Reg.	No. 2006 3026
Physicia /Medica	n al-	Decedent's Name (First, Middle, L.     Beverly	К.	Zaino	2. Date of Death Month September	Day Yeer 2 4 2006 3. Time of Death 1:12 p
Examine		4a. Facility Name (If not institution, gi  Anne Arundel Me  5. Social Security Number 6.		4b. City, Town, or Location of  Annapolis  thday) If Under 1 Year   If Under 2	4 Hrs. 8 Date of Birth	Anne Arundel
uneral irector			4 Clu offic	Yrs. Months Days Hours	Min. (Month, Day, Ye Nov 6 192	
Sa-f show	ctor	10a. State 10b. County  MD Anne A	rundel Annapo			10d. Inside City Lim 1 ☐ Yes 21
23a or 20	af Dire	930 Astern Way,	#311	10f. Zip Code 21401	10g.	Citizen of What Country?  USA
item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②○▼No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Medical	Completed	15. Decedent's E (Specify only highest gi	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	b. Kind of Business/Industry
is marked other than aumatic event, the Mi	Be	17. Father's Name (First, Middle, Las			's Name (First, Middle, Mai	Retail Store den Sumame)
7 is marke traumatic	<u>၀</u>	Edward Kramer  19a. Informant's Name/Relationship  Janis Charkow		Soph: Mailing Address (Street and Number 4 Aristotle Way,		
nt: If item 27 i ry or other tra		20a. Method of Disposition  1	☐Removal from State 20b. Place of cemeter	Disposition (Name of y, crematory or other place)	Date 200	c. Location - City or Town, State
Important: If ite any injury or of once.		21. Signature of Funeral Service Lice		22. Name and Address of Facility Hardesty Fune: 12 Ridgely Ave	ral Home, P.A	
bur bur	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to	nock ar Prennon		Inferval Between Onset and Death
2 .	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d.  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
n signed b	d by Pi	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ite has been si age 2 should	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 ☑	
is certifica director, p	To Be C	25. Was case referred to madical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 EP/Ou	Othor	of Death (Check only one) sing Home 5 \( \bigcap \) Residence	ař
	Certification;	27. Mann Ceath  1 Natural 2 Accident 3 Suicide 4 Homicide  25 Pending investigating determine	(Month, Day Year) II	ime of 28c. Injury at Work?  M 1 Yes 2 N  m, street, factory, office		t and Number or Rural Route Number,
e Funeral etely filled	edical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	Physicien: To the best of my knowledge miner: On the basis of examination an and manner stated.	, death occurred at the time, date and d/or investigation, in my opinion, death	place, and due to the cause n occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the	Me	29b. Signature and title of ortifier	<u> </u>	29c. License number		Date signed (Month, Day, Year)  9 4 06  is MD 21401
1	_				, ,	

DHMH 17 Rev 1/2001

_			For State Registrar			f Marylar	nd / Depa	artment or rtificate	of He	alth a	and M		Reg. No.	200		30270
	Physici	an	Decedent's Name (Firs.	t, Middle, L	ast)							<ol><li>Date of De. Month</li></ol>	ath Day	Yea	r	Time of Death
	/Medic		Pauline					Abro				09	18			4:50p. <sup>™</sup>
	Examin	er	4a. Facility Name (If not in			mber)		4b. City, To			f Death			ounty of De		_
			Stella Ma						owso		24 Han					
	Funeral		5. Social Security Number		Sex 1 □ M 2XDF	7. Age (In yrs. 9)		If Under 1	Days	If Under : Hours	Min.	8. Date of Bin (Month, Da	y, Year)		cirthplace Co <i>untry)</i>	(State or Foreign
	Director		219-30-354 Usual Residence of Dece			9.						)1 27	14			NC
	land ow			County		10c. Ci	ty, Town or Lo	cation							10d. I	nside City Limits
	Many	ģ	MD B	alti	more		Lutl	nervil	lle						1	I □Yes 2 □ No
	r 28a	Director	10e. Street and Number					10f. Zip C	ode				10g. Citize	n of What	Country?	
	n with	0	2300 Dulan	ev V	allev F	Road			210	093				U.S.	Α.	
	deat	Funeral	11. Marital Status		7	edent Ever in L	J.S. 13.	Was Deceder	nt of Hisp	Danic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 14	Race - Ar		ndian,
9	after or Ite	F	1 Never Married 2	☐ Married		2 XNo		1 ☐ Yes 20		Specify:	. 1 00101	ncan, etc.)	1	Black, Wi		_
93	iral',	d by	3 Widowed 4 □ D	ivorced	Year or D	ates:			4110					респу.	Bla	CK
5-(	within 72 hours after death with the Maryland Brie than "natural", or Iteme 23a or 28a-f ehow the Madical Examiner must be multified at	Completed	15. D (Specify only	ecedent's l y highest g	Education rade completed)		16a. Dece (Give	dent's Usual ( kind of work of DO NOT use	Occupati done du	ion <i>ring m</i> osi	of working	ng	16b. Kind	of Busines	ss/Industr	У
12	within iene.	E E	Elementary/Secondary		College (	1-4or 5+)	1	ouse [						Home		
.M.	filed v Hygie other I	ပိ	12th grad 17. Father's Name (First,		na_		l n	ouse v			r's Name	(First, Middle,	Maiden S			
P.	should be filed nd Mental Hygi marked other	Be c	Johnny Bu		•							Willia		ao)		
50 arvi	d Me d Me mark	ဥ	19a, Informant's Name/R				19h Maili	na Address /S	Stroot an			Route Number		Town State	Zin Cox	fo)
4:50 P.M. Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Manylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Madical Examiner must be multified at		Marie Wel	·		~		-				t 1-C,				21237
	1 an Heal Heal		20a. Method of Disposition		augiicei		Place of Disponentery, cre					ate		ation - City		State
ē	nt of nt of t: # it		1 ☐ Burial 2 ☐ Crer			State	cemetery, cre Parkw	_	er place)		/23	/06		vill		
Baltimore,	artme ortani injury		4 Donation 5 0			1			Address	1		, 00	- 0.2.			
Ba	permit. Pages 1 and 2 Department of Health a Important: If tiem 27 to eny injury or other tre 8068.		Y Leron	me	A. J	hump	30N 4		aba	sh A	ve,	Balti		, Mo		1215
	Physician /Medical		23a. Part1. Inter the dise shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or co re. List on	y one cause on	caused the dana each line.	5	ter the mode of		such as	cardiac o	r respiratory a	rrest,		Inte	proximate erval Between set and Death
2006		Ical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	as, ate	b. Due to	(or as a consec	quence of):									
SEPTEMBER 18, ords, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this centificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregrint the past 12 month 1 ☐ Yes 2™No 9 ☐ Unknown		1□Live I	tcome of pregn birth 2 ☐ Feta nant at time of d lown	al death 3[	□Ectopic preg □ Other (spec					23	d. Date of o	delivery Day	Year
ABRON SEPTEN	uires that signed t	þ	Part II. Other significant	conditions	contributing to d	leath but not re	sulting in the u	ınderiying cau	ise given	in Part I.						use of death?
Soo	w red beet shou	Completed										24a. Was	an	24b. Were	autopsv	findings available
≥	The law ate has b	E											rmed?	death	?	tion of cause of
ABRON Vital F	ifficat		25. Was case referred to	medical						26 Place	of Doath	1 ☐ Yes (Check only o		1 🗆 \Upsilon	es 2.D	NO
	s cert lirect	To Be	examiner? 1 ☐ Yes 2 ☑ No	modical	Hospital:	Inpatient 2	FR/Outpatie	nt 3[] DOA	Othor			ne 5 Resi		Other (S	nec(é <sub>t</sub> )	
VE o	Attending Physician: r death. setor: After this certific. by the funeral director,	i.	27. Manner of Death			of Injury oth, Day Year)	28b. Time o		: Injury a Work?			8d. Describe			Jecny)	
PAULINE Division o	nding tth. :: Afte	Certification:	1. S Natural 5 ☐ 2 ☐ Accident	Pending investigati		m, Day Year)	Injury	М		es 2 🔲 I	No					
AU.	Atte	Hice		Could not determine	289. Place	of Injury - At h	nome, farm, st	reet, factory, o	office		2	8f. Location (	Street and	Number or	Rural Ro	ute Number,
D P	s afte	Sert	4   Homode		Duild	ling, etc. (Speci	14)					Chy or 701	vii, State)			
	To the Hospital or Attenswithin 24 hours after death To the Euneral Director: completely filled in by the	Medical (			Physician: To the aminar: On the b											
	To the within To the comple	Me	29b. Signature and title of	f certifier		. 0 1	1	29c. 1	License	number			29d. Date	signed (Mo	nth, Day,	Year)
	F S F O		1	30.45	time	1 Ven	A, M	7 (	2	52	74	0	Sem	emb	en	1912
	1		30. Name and address of	person wh	o completed can	se of death (III	m 23a) (Tvpa	Print)								11 200
	5		ERNESTINE		·		DULANI		LEY .	ROAD	TIN	ONIUM,	MD 2	1093		
	Sta	te	31. Date filed (Month, Da			Registrar's Sign										
	Registr		ĈE	D 9 5	2000		10	Paral :								

DHMH 17 Rev 1/2001

ORIGINAL

Saifulbarribn Taifa Abdullah

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		rtificate of De	eath	R	eg. No. 200	6 3027
Physician/ Medical Examine		e,Last)	A	bdullah	2 Date of Dea Month September	th Day Year er 21, 2006	3. Time of Death 1025 hrs
	4a. Facility Name (if not institutio			ity, Town, or Location of		4c County of Death	
Funeral	Ramp from W/B I-68 t  5. Social Security Number	o High Germany R  6. Sex 7. Age (In yrs		instone Under 1 Year If Under	24Hrs 8 Date of Bir	Allegany th(MM/DD/YYYY) 9. Birt	hnlace (State or
Funeral Director	214-33-5909	1XM 2F 32		onths Days Hours	Maria	Foreig	
aus	Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Location				10d Inside City Limits
<b>š</b> .	MD NA	В.	altimore				1 X Yes 2 No
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number		101	. Zip Code	1	0g. Citizen of What Cour	try?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  ont: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 King James 11 Marital Status	Circle 12. Was Decedent Ever in U	.S. 13. Was De	21207 cedent of Hispanic Origin	n? ( Specify Yes or No	- 14 Race - Ameri	can Indian, Black,
or items 23:	1 Never Married 2 XM	1 Yes 2X No	If Yes, s	pecify Cuban, Mexican, I	Puerto Rican, etc.)	White, etc.	
rs after ural", miner	3 Widowed 4 Div	orced If Yes, Give Year or Dates: cify only highest grade completed)		No specify: sual Occupation (Give ki	nd of work done	Specify: B1 a	
72 hour n "natral al Exa	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most o	f working life. DO NOT u	se retired)		,
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	12th grade	4yrs	Sales	person		Sprint	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than aumatic event, the Medica To Be Comple		•		18.Mother's Aish	Name (First, Middle, Manne (First, Middle, M	Maiden Surname)	
212 nould be id Meni is mark	19a. Informant's Name/Relations	nip (Type, Print )		Iress (Street and Numb	er or Rural Route Nun	nber, City or Town, State,	
MC all and a standard and a standard and a standard and a standard and a standard and a standard and a standard and a standard and a standard and a standard and a standard a st	Yasmeen Abdu  20a. Method of Disposition	r-Rahman-Wife	I King	James Ci	rcle, Ba	1to, Md	21207
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Be Come	1 X Burial 2 Cremation	3 Removal from State	crematory or other p			Randalls	
Baltin permit P. Departme Importan injury or	4 Donation 5 Other Sp. Sign ture of Funeral Service	conj.		and Address of Facility ChF/H Wes		Ranadiis	zowii) iid
Ų.	maia c	. Ward	430	0 Wabash	Ave, Bal		
Physician /Medical	failure. List only one cause		i. Do not enter the mo	ode of dying, such as car	diac or respiratory arro	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)	a Multiple Injuries  Due to (or as a consequence of	of):				Boati
1	Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a consequence of	nf):				
ted nsit Examine	cause. Enter Underlying Cause (Disease or injury that initiated	с					
uted nd ransit	events resulting in death) Last	Due to (or as a consequence of d.	or):				
760, icate be executed physician and the burial - transit	UNPENDED	AMENDED					
8760, ifficate be ng physici is the buri	IF FEMALE: 23b. Was decedent pregnant in th	e 23c. If yes, outcome of preg	nancy 2 Fetal de	eath 3 Ectopic	pregnancy	23d Date of delivery Month D	ay Year
the death certify the death certify by the attending the death of the attending by the attending the death of	past 12 months?	Pregnant at time of de	a a th	Specify)	,		.,
P,O. Bo, that the desired by the a detached for both years.		ons contributing to death but not r	esulting in the under	lying cause given in Part	I. 23e. Did to	bbacco use contribute to t	he cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by Partification:					1 Yes	s 2 V No 3 Prob	ably 4 Unknown
Records,  The law require frate has been signage 2 should be					24a. Was autop		opsy findings available ompletion of cause of
Reco						rmed? death? 2 ✓ No 1 Ye	s 2 No
Vital Rec ysician: The l his certificate l director, page	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	26 Place of Death (C		Residence 6 V Other	Same
n of Vil	27 Mapper of Death	28a Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe	now injury occurred	
IVISION or Attendii filer death Director: A in by the fu	1 Natural 5 Pend 2 Accident Inves	FOUND: Day, Year) stigation Sep 21, 2006	FOUND: 1020 hrs	1 Yes 2 🗸	object	motorycle in collisi	on with fixed
Division ospital or Attending spital or Attending tours after death meral Director: After filled in by the fune Certification:	3 Suicide 6 Coul	d not be mined (Specify) Interstate/		ctory, office building, etc	or Town, S	Street and Number or Rur	
Hospit 24 hour Funera tely fill		nysician: To the best of my knowled		t the time, date and plac		W/B I-68 to High G	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Expension	one) 2 Medical Exa	miner: On the basis of examination a and manner stated.		n my opinion, death occu		and place, and due to the	cause(s)
_ /\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	29b. Signature and title of certifie	10000		29c License number  O.C.M.E.		29d Date signed (Mon September 22, 20	
2	30. Name and address of person	who completed cause of death (Item	n 23a)			300100122, 20	
2	Carol Allan, MD Ass	sistant Medical Examiner	111 Penn Stre	et, Baltimore, MD 2	21201		
State Registra	31 2 7 3 7	006 Registrar's Signati	ure forest				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** September 15,2006 /Medical Town, or Location of Death a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Hospital Johns mone n/a pluns If Under 24 Hrs. 5. Social Security Number 7. Age (Infyrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F 63 Yrs. Director 170-34-5203 <u>Pennsylvania</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ul Hygiene. other then "natural", or Iteme 23a or 28a-f shov vent, the Madical Examinar must be notified at Bel Air 1 ☐ Yes 2½ No Harford Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21015 1017 Seamount Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No δ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) geosystem Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be d 2 should be fi h and Mental F 7 le marked ot Marjorie Tuman Edgar Allan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 le any injury or other treu 1017 Seamount Road, Bel Air, Md. 21015 Margaret Graff/life partner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 Toremation 3 □ Removal from State 9/18/2006 Baltimore, Md. Bayview Crematory 4 □Donation 5 □ Other (Specify) Signature of Funeral Fervice Lin Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel air, Md. 21014 Int. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cold, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In mediate Cause (Final discase or condition resulting in death) Right Vent to Pnysician Ventrice Hour /Medical **Examiner** 40cakdiah Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit onomake Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed?
1 Yes 2 A No 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kies-oou

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who complet

25 2006

31. Date filed (Month, Day)

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

of Vital

Division

cause of death (Item 23a) (Type, Print) 600

32. Registrar's Signatura

SEREN SIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death GEORGE ALLEN DEIL 6:43 PM 2006 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Medecal BOO Ofinere N/A8. Date of Birth (Month, Day, Year) Oct. 31, 1 If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 □ F Months Hours 213-32-5657 70 7935 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Perry Hall Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21128 9603 Haven Farm Road. Unit D 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Namuth Allender George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) 9603 Haven Farm Rd., Unit D, Perry Hall, MD 21128 Gwen Allender 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 9/25/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) orsmetic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Derfora Due to or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 22 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Natural 1 Yes 2 No

Examiner Hospital or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, ours efter death.

•re! Director; After this certificate hes been signifiled in by the funeral director, page 2 should be 24 hours e

**Physician** 

/Medical

Directo

Completed by Funeral

Be

2

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-1 ehow emy injury or other traumatic event, the Medical Examinar must be putilised at once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

Examiner by Physician/Medical Completed Be Medicai Certification: To 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

SEP 2 5 2006

301 MD

who completed cause of death (Item 23a) (Type, Pint)

STIPHUL 32. Registrar's Signature

DHMH 17 Rev 1/2001

Within 2

			1 - For State Registrar	State of Mary	land / Dep <i>Ce</i>	artment of H	lealth and Death	Mental Hyg	giene Reg. No. 2	106	30274
	Physici	an	Decedent's Name (First, Middle, L.	· • ·				2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Media	cal	BATHERINE	BROWN				9	18	06	3:00 PM
7	Examir	ner	4a. Facility Name (If not institution, g UNIVERSITY OF		mard	4b. City, Town, o	Report Location of Deat		4c. County		
	Funeral			Sex 7. Age (In	yrs. last birthday)		If Under 24 Hrs	8. Date of Birth	1	n/a 9. Birthpl	ace (State or Foreign
	Director		246-48-2597	1□M 2ŌXF 72	Yrs.	Months Days	Hours Min.	Jan 8,	1934	Nort	ace (State or Foreign ry) n Carolina
	and *		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation					d. Inside City Limits
	Maryl	ō	Maryland Anne A			Crofton					1 ☐ Yes 2 🔏 No
	r 28a	rec	10e. Street and Number	Ididel		10f. Zip Code			10g. Citizen of	What Count	ry?
	th with	aiD	2094 Jason Court			2111	4		Unite	d Stai	tes.
	r dea	Iner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Rad	ce - America	n Indian,
36	s afte	by Funeral Director	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 🔀 No		,,	Specif	v:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show na Macdical Examinar mant be notified at	edt	15. Decedent's		16a, Dece	dent's Usual Occup	ation		16b. Kind of B		ack
215	hin 72	Completed	(Specify only highest g Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retired	during most of word)	rking		401110041114	250 y
21	filed wit Hygien ther th	Con	12th		Hon	nemaker			Ow	n Home	e
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M.	Be	17. Father's Name (First, Middle, Las				18. Mother's Nar	me (First, Middle,	Maiden Sumar	пө)	
ž	shoutd ind Men in marke umatic	10	Walter 19a. Informant's Name/Relationship	Crawford	105 14-16		Edna				
Na	and 2 s ealth an m 27 is I		Dan Brown, Jr./			ng Address <i>(Street</i> Jason Co		ofton, Ma			
ē	of Hea of Hea f Item		20a. Method of Disposition	20		sition (Name of matory or other place	oult GI		20c. Location		
Ë	Page nent o int: if		1 ☐Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Chemoral Itom State		Memorial	!	22/2006	Annapo	lis. N	Marvland
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if Item 27 is marked other than eny injury or other traumatic event, Ite M. 90cg.		21. Signature of Funeral Service Lio		22 L	2. Name and Addre Donaldson 411 Anna	ss of Facility Funeral	Home & C	Cremato	ry, P.	Α.
		,	23a. Part. Enter the disease, or conshock, or heart failure. List only	nplications that caused the						-	Approximate Interval Between
	Physician	2	Immediate Cause (Final disease or condition	5	EPS1	5					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):						
	,	-	Sequentially list conditions,	b Due to (or as a con	isequence of):						
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
o Î	be executed sicien and burial-transit	Exa	resulting in death) Last	c.  Due to (or as a con	sequence of):						
8760,	ate be ex hysicien the burial	Icai	•	d							
9	e as t	Med	IF FEMALE:								
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of deliver onth [	/ Day Year
ر. ص	res that igned b be deta	by Pi	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	bacco use cont	ribute to the	cause of death?
Records,	v require been sig should b							1 □ Ye	es 2 No	3 🗌 Proba	bly 4 Unknown
ecc	e law r has be je 2 sh	Completed						24a. Was a		Were autops	sy findings available pletion of cause of
<u>=</u>		Col						perforr	med?	death?	EL No
Vital	Physician: This certifical	Be	25. Was case referred to medical examiner?	Hospital:		t 3C DOA Oth		th (Check only on	(e)		
<b>5</b>		7.	1 Yes 2 No  27. Manner of Death	1 Impatient	2 ER/Outpatien 28b. Time of	3 DON	4 🗀 Nursing n	ome 5 Reside			
O	Attending ir death. ector: After by the funer	tion	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day Yea	r) Injury	Worl	k? Yes 2 ∐No	Edd. Doscribs no	ow injury occur	90	
Division	si or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not determined		At home, farm, streecify)	eet, factory, office		28f. Location (St City or Town	reet and Numb n, State)	er or Rural	Route Number,
	To the Hospitei or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my iminer: On the basis of examand manner stated.	knowledge, death nination and/or in	occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and ma ate and place,	inner as sta and due to t	ted. he cause(s)
	To the i	W	29b. Signature and title of certifier	Done	8-	29c. License	646	2	9d. Date signer	1 .	
	10		30. Name and address of person who		Item 23a) (Type,			0			
	-0		31. Date filed (Month, Day, Year)	ADEE MD	22 5	Print) GREEN	ue ) ( , ,	DATIMO	one, N	10 2	1001
	Sta Registr		51. Date med (Month, Day, 19ar)	32. Registrar's S.	-	ade					
DH	MH 17 Rev 1/20		SEP 2 5 2	006 June	J. Ago	and .					·

ORIGINAL

30275 State of Maryland / Department of Health and Mental Hygiene 2 () () 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 **Physician** Day 20 Braxton 2006 7:40p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1406 North Broadway N/A Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12 12 53 Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 27 F Yrs Director 52 219-66**-**5586 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "netural", or Iteme 23a or 28a-f ehow the Madical Examiner must be notified at MD Director NΑ Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it. Depertment of Health and Mental Hygiene. I mortant: if item 27 ie marked other then "neturel", or Items 23a or 2, and injury or other traumatic event, the Madical Exemination 2002. 1406 North Broadway 21213 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) N Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) llth grade Disabled Disabled na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Harry Epps Annie Mae Mobley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charro Jones-Daughter 4411 Norfolk Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro-Crematory Inc. 9/25/06 Baltimore, Md 4 □ Donation 5 □ Other (Specify) 21. Sign sture of Funeral Service Licenspe March F/H West 4300 Wabash Ave, Baltimore, 21215 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final MYOCARDIAL INFARCTION Physician disease or condition resulting in death) 15 MINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DISEASE 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) this. : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 No Director: 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by within 24 hours after To the Funeral Dire 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number September 22, 2006 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Veidt 600 NORTH WOLFE STREET BALTIMORE MARYLAND

State Registrar 31. Date filed (Month, Day, Year)

SEP 2 5 2006

32. Registrar's Signature

CARUES

		1	For State Registrar	State of Maryland		artment of Hertificate of L			jiene 2006	30276
	Physicia /Medic	an al -	1. Decedent's Name (First, Middle, Last)  CECILL 4a. Facility Name (If not institution, give si		341	GER 4b. City, Town, or	Location of Death	2. Date of Dear Month	Day Year	6 02;45 MM
*	Examin Funeral Director		Lorien Nursing C 5. Social Security Number 6. Sex 106-09-6081			Co1u		8. Date of Birth (Month, Day 9/6/15	Howard	
	Ra-fehow	. [	Usual Residence of Decedent   10a. State		Town or Lo	tonsville				10d. Inside City Limits 1 ☐ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other then "naturel", or items 23a or 28a-f ehow any njury or other traumatic event, Ite Madical Examiner must be notified at once.	Funeral Director	912 Kent Ave.  11. Marital Status	Was Decedent Ever in U.S Armed Forces?	S. 13.	10f. Zip Code  212  Was Decedent of Hill If Yes, specify Cubai			USA  14. Race - An Black, Wh	nerican Indian,
21215-0036	72 hours afte naturel', or it	þ	1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade		16a. Dece	1 Yes 2 No	Specify:		Specify: 16b. Kind of Busines	White s/Industry
d 2121	a filed within a line within a line within a line with a line was went, the was	Be Completed	Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 0	life.	istrative	Assist	ant	V A Hospi Maiden Sumame)	tal
Maryland	d 2 should be th and Menta 7 Is marked traumatic ev	ToB	Antony Dziedzic  19a. Informant's Name/Relationship (Type Potential of Parallel ov. //			ng Address (Street a	nd Number or Rui		r, City or Town, State	, Zip Code) FL. 34684
Baltimore, I	Pages 1 and ment of Healt ant: If Item 2 ant; or other		Patricia Buckley /  20a. Method of Disposition  1	amoval from State BaPf	ace of Dispo	sition (Name of na <b>CYEM2COY</b>	- 1	Date	20c. Location - City of Baltimore	or Town, State
Balt	Departition of the permit of t		21. Signature of Funeral Service License  23a. Part1. Ente the disease, or complice shock, or heart failure. List opy on	Centro	h 3		ns Ave.	Baltimor	ce, Md. 21	229 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of the consequence of t	CE!		EN EN.			Onset and Death
8760, A	ate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	(0 14)				ang.
.O. Box 68	that the death certifical led by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3[	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
S, D	The law requires that the tee bas been signed by thouge 2 should be detache		Part II. Dther significant conditions con	tributing to death but not resu	lting in the u	nderlying cause give	en in Part I.			to the cause of death?  Probably 41 hknown
	in: The law r ificate has be or, page 2 sh	e Completed	25 Was case referred to medical	-			26 Place of Dea	24a. Was a autops perfor 1 Yes	med? prior to death	autopsy findings available o completion of cause of ?
n	Attending Physician: The lav r death. ector: After this certificate has by the funeral director, page 2	ToB	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation		ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	4 Nursing H	ome 5 Resid	ence 6 Other (Sp ow injury occurred	pecify)
Division	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	i Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	)	- 1		City or Tow		
	o the Hos ithin 24 ho o the Fund ompletely f	Medical	29a. Certifier (Check only one)  Certifying Physical Examination (Check only one)	ician: To the best of my knov ler: On the basis of examinati and manner stated.	ion and/or in	vestigation, in my or	pinion, death occu	rred at the time, o	late and place, and d	ue to the cause(s)
)	3		30. Name and address of person who co	up te Mo	23a) (Type.	DO C	5315	0 3	SEPT 19	9 2006
	Sta Regist	ite ar	Sh Alway M Ac 31. Date filed (Month, Day, Year) SEP 25 200	A CHOU	A C	1650.	sant	ia fo	Rd Sur	MD 21045

Physici /Media Examir

**Funeral** Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

		State Registrar	,	Certificate of D	eath	Reg. N	2006	30211
		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month D	ay Year	3. Time of Death
Physici Medic		Delsie Dollie Barker				September	19, 2006	730 AM
Examin		4a. Facility Name (If not institution, give street an	nd number)	4b. City, Town, or L			c. County of Death	
		LORIPH (Q KIVARSID	e	BEL	A NO		HOR FORS	
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea.	9. Birthpi Coun	lace (State or Foreign
irector		212-28-9859 1 M 2 X	76	Yrs.		Jan. 31,	1930 WVa	
<b>≯</b>		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location			11	0d. Inside City Limits
ohe T	ō	Md. Harford		Bel Air				1 ☐ Yes 24 ☐ No
28a-	Director	10e. Street and Number		10f. Zip Code		100.0	itizen of What Coun	to/2
la or		2025 Ruffs Mill Road		210	15		U.S.A.	D Y E
ns 20	Funerai	11. Marital Status 12. Was	Decedent Ever in U.S.	13. Was Decedent of Hisp	anic Origin? (Spe	cify Yes or Nő	14. Race - America	an Indian,
	臣	Arm	ed Forces? Yes 2 ⊉No	If Yes, specify Cuban,	Mexican, Puerto F	Rican, etc.)	Black, White,	etc.
Exam	by		s, Give ror Dates:	1 ☐ Yes 2 ☐ No	Specity:		Specify: whi	te
lical	Completed	15. Decedent's Education (Specify only highest grade comple		Decedent's Usual Occupati (Give kind of work done due	on on most of working	16b.	Kind of Business/Inc	iustry
NA.	пр		ege (1-4or 5+)	life. DO NOT use retired)	ing most or workin	,9		
- 4	ပ္ပ	12 years		homemaker			own home	
d off	Be	17. Father's Name (First, Middle, Last)		1		(First, Middle, Maide		
atic o	မှ	Henry Hamrick				B. Willian		
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be multised at once.		19a. Informant's Name/Relationship (Type, Prin. Shirley Watson/daught	•	o. Mailing Address <i>(Street an</i> 2025 Ruffs Mi				
oths		20a. Method of Disposition	comete	f Disposition (Name of ry, crematory or other place)	į D	ate 20c.	Location - City or To	wn, State
int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Bel A	ir Mem. Gdns.	9/23/	2006 Bel	Air, Md.	
y in		21. Signature of Funeral Service Licensee		Schimunek F	of Facility 1 H	ome of Bel	Air, Inc	
트늘레		Mul		610 W. MacP				
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do on each line.	not enter the mode of dying,	such as cardiac of	r respiratory arrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	Munso	indial into	nction			Onset and Death
edical miner		resulting in death)	e to (or as a consequence	of):				
111111111111111111111111111111111111111	_	Sequentially list conditions, h	(Futhour	andial into	t			Years
sit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence	ot):				tant
and ii-trar	Examiner	that initiated events c.	ue to (or as a conservence	o):	_		7	ens
sicien								
phy:	Medical	d						
nding use a	-		s, outcome of pregnancy				23d. Date of delive	rv
d for	cia	in the past 12 months?	Live birth 2 🗍 Fetal death Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)				Day Year
by the	Physician	9 Unknown 9L1	Unknown					
ped e del	by P	Part II. Dther significant conditions contributing	to death but not resulting i	n the underlying cause given	in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
en sig	edi	- Schrid	phremia	·-·-		1 ☐ Yes	2 duNo 3 □ Proba	ably 4 Unknown
2 sho	Completed					24a. Was an autopsy	24b. Were autop	osy findings available appletion of cause of
ate he	mo					performed?	death?	
ctor.	Вес	25. Was case referred to medical examiner?			6. Place of Death			
his ce I dire	2	1 □ Yes 2 DNo Hospital:	1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Other:	4 Nursing Hon	ne 5 🗆 Residence	6 □Other (Specify	)
ofter t	e :	27. Manner of Death 1 Natural 5 Pending		Time of 28c. Injury a Injury Work?		8d. Describe how inj	ury occurred	
the fu	cati	2 Accident investigation			s 2□No			
Olrac in by	Certification;	determined 289.	Place of Injury - At home, fa building, etc. <i>(Specify)</i>	arm, street, factory, office	2	8f. Location (Street a City or Town, Sta		Route Number,
Filled		20a Cartifier 1 ACartifying Physician: 1	To the best of my knowledge	a double conversed at the time	data and place a		->	
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 / Certifying Physician: 1 (Check only one) 2 / Medical Examiner: On and	the basis of examination ar manner stated.	e, death occurred at the time, nd/or investigation, in my opin	ion, death occurre	nd due to the cause( ad at the time, date ar	s) and manner as stand due to	the cause(s)
To th Comp	Ž	29b. Signature and title of certifier	1 / .	29c. License r	umber	29d. D	ate signed (Month, L	Jay, Year)
		1 1 W/	Men un	1027		9	119/06	
i		30. Name and address of person who completed		(Type, Print) Now About	. 1	1 / 0		
1		ARMA McChi	2 an 611	Mac I band	10 /	Tel Hir	Mn 2101	4
Sta Registr			32. Registrar's Signature	parke				
negisti	αI	SEP 2 5 2006	Beneva B.	8				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			1 - For State Ragistrar	State of Mai	ryland / Depa Ce	rtificate of	Death		iene 2006 ag. No.	30278
	Physici		1. Decedent's Name (First, Middle, Las Esther Ilene B	•				2. Date of Deat Month	Day Year	3. Time of Death 5 • 13 D M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea		er 20, 2006 4c. County of Deat	
			Gilchrist Center			Tows			Baltimo	
	Funeral Director		5. Social Security Number 219-14-5619  Usual Residence of Decedent	ox 7. Age (	(In yrs. last birthday)  82  Yrs.	ff Under 1 Yea Months Days			Year) 9. Birtl Co	hplace (State or Foreign untry) LYLand
	yland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
:	Ba-fa	ctor	Maryland Baltimo	re		Kingsvi	lle			1 ☐ Yes 2 🕱 No
	ath with the 23a or 2	Funerai Director	10e. Street and Number 11719 Hillside R	oad		10f. Zip Code	21087	1	Og. Citizen of What Co U.S.A.	untry?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Depetriment of Heath and Mental Hygiene. Depetration of Heath and Mental Hygiene. Important: If tem 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Exeminar must be notified at once.	by	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 No	Hispanic Origin? (S ban, Mexican, Puer o Specity:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: W	
5-0	"natu	ietec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occi	pation a during most of wo	rking	16b. Kind of Business/	ndustry
212	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	///е.	DO NOT use retir Homemal	•		Own Hom	e
nd .	al Hyg al Hyg d other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
y a	Ment Ment Marked Matic e	2	Wesley Klipste				Berth		awford	
Na Na	lith and 25 is in the and 27 is n		19a. Informant's Name/Relationship (7 Edwin F. Businsky					ural Route Number, Kingsvil	City or Town, State, 2 Le. MD 21	îp Code) 087
Baltimore,	of Hea of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Domain I from State	20b. Place of Dispo	1100		Armini and a second	20c. Location - City or	
ţi Ţ	tment tment tant: h		4 ☐ Donation 5 ☐ Other (Specify	)	Bayview C	Crematori	9/2		Baltimore,	
Ba	Depermit Depermit Impor		21. Signature of Funeral Service Licen.	Rine	pan	9705 Be	lair Rd.,	Baltimor	uneral Hom e, MD 2123	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	one cause on each line.				-	est,	Approximate fnterval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Gasto	intestma	ul 60	exdry			weeles
	Examiner		0	- Dance	intestmo	Canco	er			YPAVE
PI	sit ad	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bue to (or as a	consequence of):					f****
D.	al-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence of):					
68760,	incate be executed g physicien and as the burial-transit	edical	(	d						
			IF FEMALE:	23c. If yes, outcome of						
P.O. Box	Attending Frigstrain: The law requires that the death certificate be executed to death certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  Wo 9  Unknown	1 □ Live birth 2: 4 □ Pregnant at tin 9 □ Unknown	Fetaf death 3	Ectopic pregnand Other (specify)	су 		23d. Date of deli	very Day Year
ds, P	signed b		Part II. Other significant conditions co	entributing to death but	not resulting in the u	nderlying cause g	iven in Part I.		acco use contribute to	the cause of death?
Records,	s been sign	Completed						24a. Was ar	24b. Were au	opsy findings available
E E	rnysician: The lav	E O						autopsy perform	/ prior to c	ompfetion of cause of 2 No
Vital	certific	Be	25. Was case referred to medical examiner?	Hospitaf:		0	hon	ath (Check only one	)	
Division of	grnys terthis neraldi	n; To	27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y	2 ER/Outpatien	T DON		lome 5 Reside		in Nospie
Sior	death. ctor: Af y the fur	catlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	]Yes 2 □No			
DIV	is after death rail Director:	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory, office		28f. Location (Str City or Town	eet and Number or Ru State)	ral Route Number,
2	to the nospita or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medicai	29a. Certifier Certifying Phyone) 2 Medical Exam	rsician: To the best of r iner: On the basis of ex and manner state	my knowledge, death xamination and/or inv d.	occurred at the vestigation, in my	ime, date and place opinion, death occu	e, and due to the caurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	Tot	Σ	29b. Signature and title of certifier	4.0		29c. Licer	se number	29	d. Date signed (Month	, Day, Year)
		-	30. Name and address of person who c	omoleted course of dear	th (Itam 22a) (Time	Print)	0 30 5		septembe	r 21 2006
	Ψ		Amon Chang		GGO/ \	j. Ch	arces Ji	+ BACA	une my	21204
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 5 2006	12. Registrar's	s Signature	Me ?				to the cause(s)  , Day, Year)  2 ( 2006)

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment of I rtificate of	Health and <i>Death</i>	l Mental H	ygier Reg. P	ne 20	06	30279
	Physici /Medi		1. Decedent's Name (First, Middle, Barbara Patrici	·					2. Date of D Month Septe	mber	20 <b>,</b>	<sup>rear</sup> 2006	3. Time of Death 5:30 A M
	Examir		4a. Facility Name (If not institution, Manor Care Chev 5. Social Security Number	y Chase	ber) 7. Age (In yrs.	last birthday)	4b. City, Town, Chevy If Under 1 Year			4	4c. County of Mont	Death	ry ace (State or Foreign
	Funeral Director		241-68-1581 Usual Residence of Decedent	1□M 2፟MF	63	Yrs.	Months Days	Hours Mi	rs. 8. Date of E (Month, I Februar	pay, Yea ry 15	, 1943	Count	th Carolin
	Maryland f ehow	tor	10a. State 10b. County  Maryland Mont	gomery	10c. Cit	ty, Town or Lo	antown		-			10	od. Inside City Limits 1 ☐ Yes 2 No
	an or 28a	al Director	10e. Street and Number 18039 Cottage G		ле. #2	203	10f. Zip Code	74		10g. (	Citizen of Wh		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show shy injury or other traumatic event, the Medical Examinar must be notified at ODEs.	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deced	dent Ever in U ces? 2 1 No	.S. 13.	Was Decedent of f Yes, specify Cut 1 ☐ Yes 2 ☑ No	an, Mexican, Pu	(Specify Yes or ferto Rican, etc.)	No-	14. Race Black,	White, e	
21215-0036	within 72 horsone. sne. than "naturi	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-	4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire ent Admi	during most of ward)		16b.	Kind of Busi		overnment
and 2	be filed ital Hygie od other	a	17. Father's Name (First, Middle, L	ast)				000	lame (First, Midd		•	)	
Maryland	12 should h and Mer 7 ie merke rraumetic	P	John Barrow  19a. Informant's Name/Relationsh				ng Address (Stree	t and Number or		ber, City	y or Town, St		Code) 20874
altimore, l	Pages 1 and nent of Healt int: if item 2 iry or other		James L. Barnes  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp	3 □Removal from S	20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other pla	sej	ptember 3. 2006	20c.	Location - C	ity or Tov	
Balti	permit. Departn Importa eny inju		21. Signature of Funeral Service L	icensed	MO1	1433 Be	Name and Addr thesda-C	ess of Facility Ro	bert A.	Pum 75	phrey 57 Wis	Fune	eral Home/ sin Avenue
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	ch line.	th. Do not ent	er the mode of dy $S_{\tilde{i}}$	ng, such as card	iac or respiratory				Approximate Interval Between Onset and Death
8760,	ficate be executed physicien and st the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Diseese or injury that initiated events resulting in death) Last	c	or as a consequence or as a consequence	juence of):	ekista	hic Ca	Cotan				
Division of Vital Records, P.O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending p rat director, page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 🗷 No 9 ☐ Unknown		nth 2 ☐ Feta antattime of d	ıl death 3 ☐	Ectopic pregnand Other (specify)	ey .		-	23d. Date Monti		y Day Year
rds, P.	quires thai i n signed by uld be deta		Part II. Other significant condition	ns contributing to dea	ath but not res	sulting in the u	nderlying cause g	ven in Part I.		tobacc		ute to the	e cause of death?
I Reco	: The law re cate has bee page 2 sho	Completed	-		· · · · · · · · · · · · · · · · · · ·				24a. Wa aut per 1 🗆 Yes	topsy rformed?	pride:	ere autop or to com ath? ] Yes 2	sy findings available pletion of cause of
Zita Zita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	1000				eath (Check onl)				
ō	p Phys er this eral dii	7: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		28b. Time of	3LI DOA	4/2 Nursing	Home 5 ☐ Re				
ivision	i or Attending after death. Director: After I in by the fune	Certification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ation of be 28e. Place		ome, farm, str		Yes 2 □ No	28f. Location City or T			or Rural	Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check orthy one)  Certifying 2 Medical E	Physician: To the lixaminer: On the ba and mann	sis of examina	owledge, death	n occurred at the t vestigation, in my	me, date and pla opinion, death oc	ice, and due to the curred at the time	e cause e, date a	(s) and manr and place, an	ner as sta d due to	ted. the cause(s)
)	To the within To the comp	W	29b. Signature and title of certifier					se number		- 1	20/06		ay, Year)
	Sta Registi		30. Name and address of person v Sulve Mo 31. Date filed (Month, Day, Year) SEP 2, 5 2	no completed cause	of death (Iter	Ti 23a) (Type,	D.1-1)		h 230, 7	- /			-86
			SEPAUL	COO Propage									

		-	Please	Type or F						-		egible.		
		1_ For State		State of	Marylan		artment d <i>rtificate</i>			lental Hy		200	6 3028	1
		Registrar  1. Decedent's Name (First	, Middle, Las	st)		Cel	lincale	oi Deali		2. Date of Dea	Reg. No. <sup>8</sup>		3. Time of Death	
Physic		Hilda Ca	roline	Bockmi	ller					Selfent	ner 21	Year 200	1 0 - 0	vı -
/Medi Exami		4a. Facility Name (If not in	stitution, piye	street and num	ber)		4b. City, Tov	vn, or Location	n of Death	9910		ounty of Dea		
		St. Wane		athl	are		Day	timo	C					
Funeral		5. Social Security Number		ex	. Age (In yrs.	last birthday) Yrs.	If Under 1 Y Months D	ear If Unde ays Hours		8. Date of Birt (Month, Da)	y, Year)	Co	thplace (State or Foreignuntry)	<i>j</i> n
Director		220-38-7361 Usual Residence of Deced	dent		96	,				July 7,	1910	Mai	ryland	
ylanc how			County		10c. Cit	y, Town or Lo							10d. Inside City Limit	
e Ma	Director	MD	Baltim	ore		Ca	tonsvi	11e					1 ☐ Yes 🏋ズN	0
deeth with the Maryland me 23a or 28a-f ehow LTMM DE notified at	Dire	10e. Street and Number					10f. Zip Co					n of What Co	ountry?	
eeth v	erai	709 Maide:	n Choi	.ce Lane			-1	21228	Origin? /Snr	noify You or No	USA		erican Indian.	
r fterr	Funerai	1 Never Married 2	☐ Married	Armed Ford	es? 2 🔼 No	1				ecify Yes or No- Rican, etc.)		Black, Whit	te, etc.	
D-UUSO 72 hours after natural', or its	þ	3 X Widowed 4 □ D	vorced	tf Yes, Give Year or Da	les:		1⊡Yes 2⊠	No Specif	y:		S	pecify: V	White	
72 h	Completed	15. Do (Specify only	ecedent's Ed y highest grad	lucation de completed)		16a. Deced	dent's Usual O kind of work of DO NOT use r	ccupation one during mo	ost of worki	ng	16b. Kind	of Business	/Industry	
within ene.	E D	Elementary/Secondary	(0-12)	College (1-	4or 5+)		oo not use r nemaker				0	m Home	_	
o filed with the Hygiene.	a)	17. Father's Name (First, I	Viddle, Last)			пон	lemaker		her's Name	(First, Middle,			2	
Vizand ould be file Mentat Hy arked oth	0 33	John Co	ar					A	da Ha	rding				
short and and and and and and and and and and	-	19a. Informant's Name/Re	alationship (7	Type, Print)		19b. Mailir	g Address (Si	reet and Num	ber or Rura	I Route Numbe	r, City or T	own, State,	Zip Code)	
C, N 1 and 2 Health em 27 I		Richard B.		ller, J							onsvi	.11e, N	MD 21228	
Pages 1 lent of H nt: If Ite ry or oth		20a. Method of Disposition 1X Burial 2 ☐ Cren		Removal from S	tate 20b. P	lace of Dispo emetery, crer	sition (Name on natory or other	of place)	С	Date	20c. Loca	ition - City or	Town, State	
rmit. Pa spartmen sportant: by Injury ICE.		4 Donation 5 0			Lou	idon Pa	rk Cem	etery	9-2	5-2006	Balti	more,	Maryland	
Dallimore, permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of uneral S	A C			22	uneral	Home	of Ca	tonsvil	le, I	nc.	ab-Witzke	
	-	23a. Part1. Enter the dise	ase or comp	olications that ca	used the death							1110,	MD 21228 Approximate	
Physician		shock, or heart failur Immediate Cause (Final	e. List only o	one cause on ea	ch line.		1.5 1			1	3		Interval Between Onset and Death	
/Medical		disease or condition resulting in death)		aDue to (o	r as a consequ	uence of):	NC JA	neurys	WC K	uphre			3 hrs 30.	7110
Examiner		Sequentially list conditions	s I	b										
si ad	Examiner	Tany, leading to minusofa cause. Enter Underlying Cause (Disease or injury		Dua to (a	ras a oursequ	Janea of):								
ou, be executed be executed icien and burial-transit	хап	that initiated events resulting in death) Last		c	r as a consequ	uence of):								-
- 40 -	Sal E		l	đ										
The law requires that the death cartificate The law requires that the death cartificate ate has been signed by the attending phy-	ledic			. d										
ath cert	Physician/Medi	IF FEMALE: 23b. Was decedent pregn	ant	23c. If yes, outc	ome of pregna th 2  Fetal		Ectopic pregn	ancy			230	d. Date of del		
e deal	sicia	in the past 12 pronth:	s?		nt at time of de		Other (specif					Month	Day Year	
hat the deby 1		9 ☐ Unknown  Part II. Other significant of	onditions or	antributing to des	ith but not recu	ulting in the u	doshina caus	n suron in Bod		330 Did to	hansa usa	anatributa t	the cause of death?	
uires ti signe Id be d	d by	HTN	onditions co	orithoding to dea	un bat not 145	241179 II 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	idenying caus	a given in Fan	i i.	238. Diù (0	. /	P. Contraction of the Contractio	robably 4 Unknow	n
w raqu been shoul	Completed	7,77								24a. Was			utopsy findings availabl	
T T T T T T T T T T T T T T T T T T T	E C									autop perfor	me/i?	prior to death?	completion of cause of	0
en: T	Be C	25. Was case referred to r	medical					26. Plac	ce of Death	1 ☐ Yes (Check only or		1 L Yes	2 □ No	
nysici	TO B	examiner?		Hospital: 1 🗀 In	patient 2	R/Outpatien	t 3 DOA	Othor		ne 5 Resid	1	— ∃Other <i>(Spe</i>	cify)	
ding Phy th. : After thi		27. Manner of Death	Pending	28a. Date of (Month	Injury Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe h				
Attendi	cati	2 Accident	investigation Could not be				М	1 Yes 2						
or Al efter of Direction by	Certification:	4 Homicide	determined	280. Place 0	of Injury - At ho g, etc. (Specify	me, farm, str	eet, factory, of	fice	2	28f. Location (S City or Tow		Jumber or Ru	ural Route Number,	
To the Hospitel or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2		29a. Certifier	ertifying Ph	ysician: To the b	est of my kno	wledge, death	occurred at ti	ne time, date a	and place, a	and due to the o	ause(s) an	nd manner as	stated	
ne Ho	edicai	(Check only 2 M	edical Exam	niner: On the bas and manne	is of examinat	tion and/or inv	estigation, in	my opinion, de	eath occurre	ed at the time, o	date and pl	ace, and due	to the cause(s)	
Within Comp	Σ	29b. Signature and title of	certifier					cense number		1			h, Day, Year)	
		1 -		m. (h	eckley			B(99	9 147	95	Sej	nkmb	w 21, 200	6
10		30. Name and address of	11			23a) (Type,	Print)	1 ch	1111	in ile	2011	an male	MD 2122	9
/ 61	ate	31. Date filed (Month, Day	<del>-\-</del>	J.,	heckly gistrar's Signa	ture	700 ).	C41611	MU	suc !	Jumi	riort,		/
Regist		A	MODE	2000	A.		Costi	E .						
DHMH 17 Rev 1/2	2001	3	17 % 0	ZUUD sager	el Com	adial of	A Company						·	_
						ORIGI	NAL							

			1- For Amend #16a Per Registrer	State of Marylar FH G859 /2	nd / Bepa 5/06/21	rtment tificate	of He	alth and eath	d Ment	tal Hygid Reg	ene 20	06	30281
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	ASINA					l N	ate of Death South	DayST R219	Year 6	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s NORTHWEST HOSPITA					ocation of De			4c. County of BALT I		
	Funeral Director		5. Social Security Number 6. Sex 216-45-4157		last birthday) Yrs.	If Under 1 Months E		f Under 24 H Hours M		ate of Birth 2712/1	923	9. Birthp	lace (State or Foreign
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
	the Mar 28s-f el	Director	MD BALTIMO	RE	NIWO	IGS MIL				100	g. Citizen of W	/hat Coun	1 ☐ Yes 2 No
	23a or	alDII	28 RICHMAR ROAD,	APT. E		101. Zip 01		21117		10,	g. Olli2011 01 44	mat coun	USA
220	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiane. If health and Mental Hygiane. If marked other than "natural", or items 23a or 28a-f ehow other treumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Mill Divorced	2. Was Decedent Ever in C Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Deceder f Yes, specify I ☐ Yes 2	/ Cuban,	anic Origin? Mexican, Pu Specify:	(Specify ) erto Rican	res or No- i, etc.)		k, White,	an Indian, etc. WHITE
D-C   7	iithin 72 hoi ne. nen "neturi Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual C kind of work OO NOT use	done dur. retired)		•		Sb. Kind of Bu		dustry
7	2 should be filed within and Mental Hygiene. Ie marked other than eumatic event, the Ma	Be Cor	17. Father's Name (First, Middle, Last)	5+							MEDICAL		
l yla	should b ind Menti marked umatice	To	IDEL  19a. Informant's Name/Relationship (Type	pe. Print)	BAS I		Street and	RACH.		ite Number. i	City or Town, S	State. Zin	LIPKINA Code)
S. S	1 and 2 : Health ar sm 27 to other treu		TATYANA REZNIKOV			RICHMAF	R RO			E - OW	INGS MI	LLS,	MD 21117
5	permit. Pages Department of I Important: If Its eny injury or of		20a. Method of Disposition  1	emoval from State	cemetery, cren LTIMORE	natory or othe	er place)	EM 9/	22/20		C. Location - C		
	permit. Departr Imports ony inj		21. Signature of Funeral Service License			Name and					ON & BE		INC. MD 21208
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the dea e cause on each line.								,	Approximate Interval Between Onset and Death
ı	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consec		0101	<u>u</u> (	MARC	IMO	AM			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec		= 11	VER						
ĵ	icate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consec		EPHA?	lop	HTHY	1				
0/00	ficate be physical stree bu	edical	<b>U</b> d.										
.O. DOX	To the Hospital or Attending Physicism: The law requires that the death certific within 24 hours alter death: within 24 hours alter death: To the Funerial Director: After this certificate has been signed by the eltending p completely filled in by the funeral director, page 2 should be deteched for use as	Physician/Me	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	Sc. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 0 9 Unknown	al death 3	Ectopic pregi Other (speci			-	···	23d. Date Mon		ny Day Year
L 'cn	signed b	ð	Part II. Dther significant conditions conf	ributing to death but not res	sulting in the ur	nderlying caus	se given	in Part I.	2				e cause of death?
	sicisn: The law req	Completed							-	4a. Was an autopsy performe	24b. W	/ere autor rior to con eath?	osy findings available inpletion of cause of
la I	icien: sertifice ector, p	Be	25. Was case referred to medical examiner?				1 - 1	6. Place of D		/	a 140		-
5	g Phys er this eral dir	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Other: Injury at Work?				ce 6 □Othe		')
2	ttendin death. ctor: Aft / the fur	Certification:	↑SNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	Injury	М	1 Tes	s 2 No	286 1	ocation /Stre	et and Numbe	or Pura	I Route Number,
2	ital or A	Certif	4 Homicide determined	building, etc. (Speci	fy) 				C	ity or Town,	State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  2. Medical Examin	icien: To the best of my known:  On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at I	the time, my opini	date and pla ion, death oc	ce, and di curred at	ue to the cau the time, date	se(s) and man and place, a	ner as stand nd due to	ated. the cause(s)
	To To the me	Σ	29b. Signature and title of sertifier	mestar		D	1	410		S		(Month, L	Day Year)
う	1		30. Name and address of person who cor	npleted cause of death (Item		Print) Jo						2	
Í	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 5 2006	2. Registrar's Sign	ature	de s			-1		~ ` '		

_			1 - For State Registrer	Stat	e of Maryla	•	artmen rtificate					giene Reg. No 2 (	006	302	82
	Physici /Medi		1. Decedent's Name (First, Mid	BAAUS	NER						2. Date of De Month SENTSA	Day	Year Zw	3. Time of D	P M
	Examir		4a. Facility Name (If not institution   Covered to the control of the covered to			tr	C	rur	Location o				nty of Death	)	
	Funeral Director		5. Social Security Number 132-10-5282	6. Sex 1 ☐ M 2 √		. last birthday) 94 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin 11/12/	1911	9. Birth	place (State or ntry) NY	Foreign
	Maryland f ehow	or	Usuel Residence of Decedent  10a, State  10b, Coun  MD  H0	ward	10c. C	ity, Town or Lo	ocation JMBIA							10d. Inside City	
	an or 28e-	i Direct	10e. Street and Number 10200 HICKOR		ROAD #20		10f. Zip	Code		2104	4	10g. Citizen o	of What Cou	ntry? USA	
920	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or Iteme 23a or 28e-f ehow appringuty or other traumatic event, the Medical Examinatic Examination of the Incillingual Ance.	by Funeral Director	11. Marital Status 1 Never Married 2 🛣 Ma 3 Widowed 4 Divorce	rried 1 1 1	Decedent Ever in I od Forces? Yes 2 X No s, Give or Dates:		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 14. R B	ace - Ameri lack, White, cify:		
21215-0036	ed within 72 horgiene.	Completed	(Specify only high Elementary/Secondary (0-12)	1 <sup>Colle</sup>	eted) ega (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us TOR	rk done a	luring mosi )			16b. Kind of	INES	dustry	
Maryland	ould be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle MOSES	e, Last)		FALL	.ICK			n's Name MARY	(First, Middle,	Maiden Sum		(NOWN)	
	and 2 sho Balth and In 27 le my		19a. Informant's Name/Relation		HTER	5409	KILL	INGW		WAY	- COLU				
Baltimore	Peges 1 nent of He ant: if Iter ury or oth		20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		from State	Place of Dispo cemetery, crei BREW YC	matory or o	ther place			/2006	20c. Location	n - City or T DLAWN ;		
Balt	permit. Departi		21. Signature of Puneral Service	e Licensee	•		2. Name an 3900 H			30	L LEVIN ROAD -				08
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart fillure. Li Immediate Cause (Final disease or condition resulting in death)	st on y one cause	hat caused the dear on each line.  SEPSIS e to (or as a conse	WITH quence of):	SIHO	ck	g, such as	cardiac	r respiratory ai	rrest,		Approximate Interval Between Onset and De 48 Imm	eath 25
,160,	eath certificate be executed attending physicien and for use as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>6</b>	e to (or as a conse	quence of).									13
89	rifficate to ng physical as the t	Medical	IF FEMALE:	d											
.O. Box	The law requires that the death certifica ete hes been signed by the attending ph page 2 should be detached for use as if	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 🗀 L 4 🗆 F	s, outcome of pregr Live birth 2 ☐ Fet Pregnant at time of Jnknown	al death 3	Ectopic pr Other (sp					1	Date of deliv Month	ery Day Ye	ar
<u>α</u>	quires that the death n signed by the atte uld be detached for		Part II. Other significant condi			sulting in the u	nderlying c	ause give	in in Part I.			obacco use co		he cause of dea	
Records,	sician: The law requir certificete hes been si irector, page 2 should	Completed by	PERPUERM	- VASCUL	AR DISJ	rye						rmed?	o. Were auto prior to co death? 1 \( \subseteq \text{Yes}	ppsy findings av	vailable use of
Vital	Physician: this certifice ral director, p	Be	25. Was case referred to medic examiner?					015		of Death	1 Yes		10 165	254110	
of	Phy this rald	lon; To	1 Yes 2 No  27. Manner of Death Natural 5 Penc	28a. [	1 X Inpatient 2 C 2 te of Injury (Month, Day Year)	28b. Time o Injury		8c. Injury Work	at		me 5 Residence 128d. Describe 1			(y)	
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Coul	mined 289. I	Place of Injury - At I ouilding, etc. (Spec	home, farm, str lify)					28f. Location (S City or Tox	Street and Nur vn, State)	nber or Aur	al Route Numbe	97,
_	• Hospite 24 hours • Funerel etely filled	Medical C	29a. Certifier 1 Certify (Check only 2 Medical	d Examiner: On t	o the best of my kn the basis of examin manner stated.	owledge, deat ation and/or in	h occurred vestigation,	at the tim, in my op	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) and i date and place	manner as s e, and due t	tated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certif	er LQ				. License				29d. Date sign			
1			30 Name and address of asset	n who complete	ones of death ("	m 22a\ /T		1) 5	697	4		SAP 2	0,20	NE	
V	1		30. Name and address of person 10724 UTTLE PAT	WHENT PLI	MY, CURUI	msiA m	n 21	524-4							
	Sta Registi		31. Date filed (Month, Day, Yea SEP 2 5 1	2006	32. Registrar's Sign	ature	Es?					1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 30283 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 22, 2006 6:20 PM Anna Mabel Colly 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 6802 Golden Ring Road, Apt. A Rosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 1 □ M 212 F 85 03/02/1921 Marylánd 218-22-2923 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2XONo Maryland Baltimore Rosedale 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 6802 Golden Ring Road, Apt. A 21237 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 25No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ZXNo Specify: Specify: White 3℃Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Westinghouse Purchasing Agent 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Anastasia Miller unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Colly (Son) 3818 Federal Avenue, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/27/2006 Baltimore, Maryland Gardens Of Faith 21 Signature of Euperal Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death other the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Eretro Vascular accident Immediate Cause (Final disease and condition resulting in death) Due to (or as a consequence of): HBP 25 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of IF FEMALE 23d. Date of delivery opic pregnancy Month Day Year er (specify) 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE LUNG DISEASE 2 No 1 Yes 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

filed within 72 hours after deeth with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

r than "naturel", or items 23e or 28a-f show the Medical Examinar must be notified at

other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked other sny injury or other traumatic event.

Direct

Funeral

ģ

Completed

Be

The law requires that the death certificate be executed the attending physicien

Examiner

Physician/Medical

þ

Completed

Be

Certification;

Medical

cete hes been signed by page 2 should be detacl this certificate After

filled in by the Director

within 24 hours a

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ecto 5 ☐ Oth
Part II. Other significant condition	is contributing to death but not resulting in t	the under

24a. Was an autopsy performed? 1 ☐ Yes 2√2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 PAesidence 6 Other (Specify) 1 ☐ Yes 2 1 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 WNatural 5 Pending

1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of per figure 29d. Date signed (Month, Day, Year) 29c. License number 9/25/06 MD D 22652

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sr. S. S. R. I. N. V. A. S. 560 LOWRAVEN BL BLUD

BALTIMORE MD 21239

State Registrar 31. Date filed (Month, Day, Year)

2 5 2006

06-06824 Stanley Cherry

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

20	0	6	3	0	2	8
----	---	---	---	---	---	---

		Registrar		Certificate of	of Death		Reg	No. 200	0 0020	
Physici ledical Exami		Decedent's Name (First, Middle,Last)					2 Date of Death Month September	Day Year 10, 2006	3. Time of Death 0243 hrs	
- · · · · · · · · · · · · · · · · · · ·	4a. Facility Name (if not institution, give street and number)  4b.					r Location of Deat		4c. County of Dear	h	
Funeral Director		Social Security Number     6	If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min.				gn			
Birector		188-46-1099 1	M 2 F	53 Y	rs.		April 6	,1953	PA PA	
ж ану		10a. State 10b. County	10c. City, Town or Loc	No. all of the second s				10d. Inside City Limits  1 X Yes 2 No		
Maryland 28a-f show	ctor	PA Fayett  10e. Street and Number	te	Smock	10f. Zip Code		10g	10g. Citizen of What Country?		
th the Ma 23a or 28 notified a	Funeral Director	158 North Morgantown Street 15401								
th with ems 23		11. Marital Status  1 X Never Married 2 Marri	12. Was Decedent	If	Vas Decedent of H Yes, specify Cuba			14. Race - Ame White, etc.	rican Indian, Black,	
iter dea i", or it	3 Vyidowed 4 Divorced in test of test (Office)						Specify B1	ack		
nours al matural Examin	ed by	15. Decedent's Education (Specif		during	ent's Usual Occup most of working lif			6b. Kind of Business	/Industry	
36 hin 72 l than "y	Completed	Elementary/Secondary (0-12)	College (1-4 or		al Miner			Coal		
215-0036 be filed within 7 nal Hygiene ked other than ent, the Medica		17 Father's Name (First, Middle, L					e (First, Middle, Maiden Surname)			
2121 ould be fi Mental marked	To Be	William A. Cherry, Jr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours all Department of Health and Mental Hygiene Important: If iren 27 is marked other than "natural nightry or other traumatic event, the Medical Examining or other traumatic event, the Medical Examining or other traumatic event, the Medical Examining or other traumatic event, the Medical Examining or other traumatic event, the Medical Examining or other traumatic event, the Medical Examining or other traumatic events.	F	Gwenn Cherry/S:		126	E. Secon	d Street	, Grindst	one, PA	15442	
ore, less land of Healt litem		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from St	20b. Place of Disp crematory or Nat 1 on a	osition (Name of conther place)  Cemete:	emetery, rv of	Date	20c. Location - City o		
Pag nent ant: or of		4 Donation 5 Other Spe 21 Signature of Funeral Service	cify	the All	eghenies Name and Addre	9-	-19-06	Bridgevil eral Home		
Balti permit Departr Import	1	1/2000 (2)	Mange		97 East	Main Str	eet. Unio	ntown. PA		
Physician		23a. Part I. Enter the disease, or c failure. List only one cause o	omplications that caused in each line.	I the death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death	
/Medical Examîner	200	Immediate Cause (Final disease or condition resulting in death)	a Hanging  Due to (or as a cons	equence of):					Death	
		Sequentially list conditions,	b							
	iner	if any, leading to immediate cause. Enter Underlying Cause (Clasease or with the timitate)  Due to (or as a consequence of):  c.								
cuted md transit	Examiner	events resulting in death) Last  Due to (or as a consequence or):								
68760, certificate be executed iding physician and se as the burial - trans		X UNPENDED	AMENDED #23a.	27 282-f po	nME.08601	n/26/06 TT	1			
68760, certificate be exe dring physician a	ian/Medical	IF FEMALE. 23b. Was decedent pregnant in the	23c If yes, outco	me of pregnancy		3 Ectopic preg		23d. Date of delive	Day Year	
	ician	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (Specify)								
Division of Vital Records, P.O. Box its the the thospital or Attending Physician: The law requires that the death within 24 hours after death. To the thorsal breveor: After this certificate has been signed by the attent companiesty filled in whe the finneral director mase 2 should be detacted for us	Physici	1 Yes 2 No 9 Unkr	9 OHKHOWH	th but not resulting in th	ne underlying caus	e given in Part I	23e. Did tob	acco use contribute	to the cause of death?	
, P.O.			one continuing to dea				1 Yes	2 No 3 Pr	obably 4 Unknown	
ords, v require s been si	leted						24a Was a autops	y prior to	autopsy findings available completion of cause of	
Division of Vital Records, P.O at or Attending Physician: The law requires that t is after death.  The Third is a property of the property of							perform 1 <b>Y</b> Yes 2			
Vital Revysician: The his certificate director, was	4.		Hospital:			Other		Residence 6 Oth	ner:	
n of Vi ding Physi After this funeral dir	2	1 Yes 2 No	28a. Date of In	ient 2 ✓ ER/Outpati jury 28b. Time		njury at Work?		ow injury occurred		
on of ending Pl sath. or: After	Certification:	1 Natural 5 Pend			:53 am	Yes 2 No	subject	hanged self		
Divisior pital or Attend ours after death erral Director:	tifica	2 Accident Investigation Investigation 3 X Suicide 6 Could not be Could not be								
Divisior Bospital or Attent 24 hours after death Funeral Director				found at home Cumberland, MD  f my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started						
To the Hospita Within 24 hours	Medical	(Check only one) 2 Medical Exam	miner: On the basis of ex	amination and/or invest	tigation, in my opin	ion, death occurre	d at the time, date a	and place, and due to	the cause(s)	
5 ¥ 5 8	Me	29b Signature and title of certifie				ense number		29d Date signed (f		
		1 M	1.11	dooth (Hom 22a)		C.M.E.		Cepternoer 10,		
7		30. Name and address of person  Jack Titus MD. Dep	who completed cause of outy Chief Medical		Penn Street, E	altimore, MD	21201			
	Stat	a 31. Date filed (Month, Day, Year)		rar's Signature	4					
Reg			2006	the for	sails					
DHMH 17 Rev	1/200			ORIGI	NAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200630285 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O9 **Physician** Rose Marie Coster 11:25 AM /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tranklin Square tospital Baltimore dale If Under 24 Hrs. Year Days 8. Date of Birth (Month, Day, Year) Oct. 31, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Months Hours 217-24-0368 77 Maruland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahov injury or other traumatic avant, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9404 Snyder Lane 21128 U.S.A. or itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "na eny injury or other traumatic avant security." (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 12 School Bus Driver Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore J. Tremper Marie C. Landerkin ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie T. Molino (daughter) 9113 Sandra Park Rd., Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9/22/2006 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee Buen 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading 1 immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attanding Physicien: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ardiomyopathi 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diratory distress 1□ Yes 2 No after death.

Director: After this certific
I in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 27. Manney of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide perlij within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 19/06 egenta

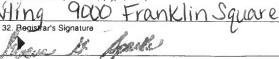
State Registrar

15

31. Date filed (Month, 9ay, Year)

SFP 2 5 2006

Name and address of person who completed cause of death (Item 23a) (Type, Print)



		State of Maryland / Department of Health and Men 1- State Amend Item 21 per FH, G859, 09/25/06dhb Certificate of Death	ntal Hygie Reg	ene2006 30286				
Physici /Medic Examir	cal		Date of Death Months	Day Year 3. Time of Death  Year 10 PM  4c. County of Death				
		Genesis Eldercare - Loch Raven Baltimore		Baltimore				
Funeral Director		5. Social Security Number 236-22-1245  1 M 2 F 85  7. Age (In yrs. last birthday) 1 Vrs.  1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.  July 1 Vrs.  1 Under 24 Hrs. Months Days Hours Min.  July 1 Vrs.  1 Under 24 Hrs. Months Days Hours Min.	Date of Birth (Month, Day, ) une 13,	9. Birthplace (State or Foreign Country) 1921 West Virginia				
yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
e Mar	Funeral Director	MD Baltimore Nottingham		1 ☐ Yes 🛣 No				
with th	Dire	10e. Street and Number 10f. Zip Code		g. Citizen of What Country?				
99th v	era	9625 Dundawan Road  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify		USA  14. Race - American Indian,				
within 72 hours after deeth with the Maryland with an Panel.  ene. than "natural", or iteme 23a or 28a-f show the Maryleal Exerciting Famel be notified at	by	11. Marital Status  1 Never Married  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto Ricant In Yes, Sive Year or Dates:	an, etc.)	Black, White, etc.  Specify: White				
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  X—ray Technician	16	Sb. Kind of Business/Industry  Medicine				
e filed wi al Hygien other th		1 X-ray Technician  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	irst. Middle. Ma					
o a a o o o	To Be	E. Samuel Meadows Trixie (						
2 should be and Menta is marked	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Ro	oute Number, (	City or Town, State, Zip Code)				
1 and 2 Health a tem 27 is		William H. McCaffrey (husband) 9625 Dundawan Road, Not						
permit. Pages 1 a Department of Hea Important: If Item any injury or othe QRGs.		20a. Method of Disposition  1 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 Donation Park Cemetery		oc. Location - City or Town, State				
permit Depart Import any in		21. Signature of Funeral Service Licensee  James T. Schwartz per DVR  22. Name and Address of Facility Schimunek Funeral Hor	mes,970	05 Belair Rd.,Baltimor MD 21236				
ne death certificate be executed  The attending physicien and the for use as the burial-transit are	Physiclan/Medical Examiner	Due to (or as a extremely list continuity flat continuity flat continuity flat continuity flat continuity flat continuity flat cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a extresquence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	litus	yens				
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown		23d. Date of delivery Month Day Year				
law requires that the de as been signed by the 2 should be detached	Ď	Patt it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.	23e. Did toba	cco use contribute to the cause of death?				
G 25 C1	Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 9 yes 2 No				
Physician: The I this certificate ha	Bec	25. Was case referred to medical axaminer?		X				
Physic this ce	ို	1 ☐ Yes		ce 6 □Other (Specify)				
Sing After funer	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f.		r injury occurred  set and Number or Rural Route Number,				
Hospital or Al 4 hours after ( Funeral Directely filled in by		4 Homicide building, etc. (Specify)	City or Town,	State)				
To the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)						
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 1	9/19/2006				
		VUONTEN 6331 Below	Rd	Balgo 1 W21206				
St Regist	ate rar	SEP 2 5 2006						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Lagiple. 30287 Amend #5 Per FH G862 12/26/06 JH

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day SEPTEMBER 19 **Physician** 20:36 bnalo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND MEMORIAL HOSPITAL ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) <sup>5. S</sup>217-30-2014 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 M 2 □ F Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location if item 27 is marked other than "naturel", or iteme 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at 1 Pres 2 No Director MD Allegano mber 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 507 Greeny Completed by Funeral 12. Was Decedent Ever in U.S. Armed Eorces?
1 ☐ Yes 2 ☐ No Mar irrelifyes, Give Year or Dates: 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Mexical Examination. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory lire WOXKEY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Resh surne reng 19a. Informant's Name/fielationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) doughter 439 N. Wayer ley lerrox e Comberland, MD 20c. Location - City or Town, State heru Tu Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 78-010 Balto, MD 4 □ Donation 5 □ Other (Specify) Metro Gremoitoru 21. Signature of unera Service License 22. Name and Address of Facility 1232 midually Dr Jessup, PA 18434 eno Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Cardiac Physician Irrhythmia Seconds /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine p physicien and stranslt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ned by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 XNo 3 Probably 4 Unknown Completed Pulmonary Obstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificete has autopsy performed? History of K 25. Was case referred to medical ulmonary 1 ☐ Yes 2 No Embolism 2 No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 🖫 ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 KNaturat Injury 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ro the Hospital 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD Home ( Hand September 21,2006

Registrar

State

Avenue

425 Kent

32. Registrar's Signature

Cumberland MID. 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Shakil

SEP 2 5 2006

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		irtment of He tificate of D			<sup>ene</sup> 2006	30288	
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
	Physici /Medio								6 5 <b>:</b> 00а м		
1	Examin		4a. Facility Name (If not institution, give st	eet and number)		4b. City, Town, or I			4c. County of Deal	_	
			Vantage House				umbia			ward	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y July 17	(ear) 9. Birt	hplace (State or Foreign	
	Director		Usual Residence of Decedent		96 Yrs.			July 17	, 1910 west	t Virginia	
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
	Man	ţo	Maryland Howard Columbia							1 ☐ Yes 2½ ☐ No	
	or 284	<u>je</u>	10e. Street and Number	-	10f. Zip Code			. Citizen of What Co	ountry?		
	n 72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show circal Exacilitat must be notified at	Funeral Director	5400 Vantage Poin	Point Road		21044			U.S.A.		
		ne.	11. Marital Status	. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
36	or It	Ϋ́F	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2X No Specify:			Specify: T.T.		
21215-0036	hour tural	Completed by	3 ☑ Widowed 4 □ Divorced  15. Decedent's Educa	The residence of the second		16a. Decedent's Usual Occupation			b. Kind of Business/Industry		
15	- 2	plet	(Specify only highest grade	completed)	(Give	kind of work done du DO NOT use retired)	uring most of working	ng '	D. Tana of Dasings	mustry	
212	d within jiene. r then "	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Regis	stered Nur	cse		Health	care	
	be filed withintal Hygiene. Id other then event, the M	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	uiden Surname)		
<u>Jar</u>	ould be Mental narked o	ToE	Isaac Newton Rudd	le			Susan D	ahmer			
Maryland	2 sh and is m	i	19a. Informant's Name/Relationship (Type			-			City or Town, State, 2		
	1 and 1 Health em 27 other tr		Robert Douglas Jon						endship, N		
ore	Pages 1 and 2 should nent of Health and Men int: if item 27 is marke iry or other traumatic		20a. Method of Disposition 1	noval nom State		sition (Name of natory or other place			c. Location - City or		
ij	t. Pa tmen tant:		4 □Donation 5 □Other (Specify)		Lakemont	Cemetery	9-22-	2006 Da	avidsonvil	lle, MD	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Licenses	kma-	189	Tzke fune	eral Home	s Inc.	mbia, MD 2	21045	
			23a Part1. Enter the isease, or complication		death. Do not ente	er the mode of dying,	, such as cardiac o	r respiratory arres	t,		
	Physician	y 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to pras a consequence of):								
7	/Medical										
н	Examiner		Sequentially list conditions b	Ane	Dun	0-1	9				
	ם יו	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
	rificate be executed og physician and as the burial-transit	cam									
60,	be ex	al E									
68760,	ificate be executed g physician and as the burial-transit	edical									
	certii nding use a	N/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. Date o		ivery	
n the past 12 months?  □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □							Month Day Ye				
P.0		hys	9 Unknown								
	S C O	by P	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.					23e. Did toba		o use contribute to the cause of death?	
ğ	w require been sig	ted						1 Yes 2 No 3 Probably 4 Unknown			
Records,		ple						24a. Was an autopsy			
								performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No			
/ita	ilcian: Th certificete rector, pag	To Be	25. Was case referred to medical examiner?				26. Place of Death				
of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification and the funeral Director: After the completely filled in by the funeral director;		TE TOS ZENO	spital: 1 Inpatient	2 ER/Dutpatien		41 Nursing Hor		ce 6 ☐Other (Spe	cify)	
		lon	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	nar) Injury	Work'	at ? es 2 □No	28d. Describe how	mjury occurred		
Division	deat deat ctor: y the	flca	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, str			28f. Location (Stre	et and Number or Ru	ural Route Number,	
Š	afor / s after i Dire	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Town, State)		
	t hours uners ely fille									s stated.	
	ithin 2 o the l	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
	F 3 F 8		11. 1		2	1	11/1	- 2	1201-1		
	1.7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						2122			
	W.		Willie B. MVE	UBA 0	un III	3 Carill	eville	He All	catousi	le un	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature			1-6-10			
	Registr	ar	SEP 2 5 280		M A	and B					

		•	For State Registrer	State of	Marylan	d / Depa	artment of tificate of	Health a	and Me	ental Hyg	iene 20	06	30289
	<b>U</b>		1. Decedent's Name (First, Middle, La	ist)					2	2. Date of Deat	th	rear .	3. Time of Death
	Physici /Medio			Jonathan	W. Cur	mmings			S		er 21, 2		7:10 PM <sup>M</sup>
	Examir		4a. Facility Name (If not institution, gir	e street and numb	oer)	_	4b. City, Town,	or Location o	of Death		4c. County of	Death	
				ech Aveni			W115 do 4 V 5	Bethe				lontgo	
	Funeral Director		009-12-4953	Sex 7. 1 X M 2 □ F	Age (In yrs.	Yrs.	Months Days		Min.	B. Date of Birth (Month, Day, eptember	Year) 23, 1925	Country	e (State or Foreign rmont
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d	. Inside City Limits
	Maryli f • ho	ō				,,		D - 41	_ 1 .				1 ☐ Yes 2 ☑ No
	the 288-	Director	Maryland Monts  10e. Street and Number	gomery			10f. Zip Code	Bethe	saa	1	0a. Citizen of Wh	at Country	?
	3a o		5000 Ro	ech Aveni	10			20817	,		Uni	+ 0.4 S	States
	deat	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.		Was Decedent of	Hispanic Orio	gin? (Speci	fy Yes or No-	14. Race	American	Indian,
36	ges 1 and 2 should be tiled within 72 hours atter death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow or other traumatic svent, the Modical Examiner must be inclified at	by Fui	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Date	□ No		f Yes, specify Cul 1 □ Yes 2 🕅 No		і, Риепо ні	ican, etc.)	Specify:	White, etc	hite
ğ	2 hou	ted	15. Decedent's E	ducation	WWII		tent's Usual Occu				16b. Kind of Bus		
215	thin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	kind of work done DO NOT use retin	aduring most ad)	t of working	7			
7	Hygien Hygien other the	Son		5+		C	linical					cholo	уду
nd	be tile tal Hyg d othe svent,	Be	17. Father's Name (First, Middle, Last	)				18. Mothe	er's Name (	First, Middle, I	Maiden Sumame,	)	
<u>ya</u>	2 should be 1 and Mental   is marked o raumatic sve	2		nley Cum	nings						e Greene		
Mai	nd 2 shallth and 27 is n		19a. Informant's Name/Relationship		h a sa						, City or Town, S		
e,	1 and Healt em 2		Abigail Cumming 20a. Method of Disposition	s/ Daugni	20b. P	lace of Dispo	sition (Name of		eet,		ton, Vir 20c. Location - C		
lon I	Pages 1 and ment of Healt ent: If Item 2 ury or other		1 ☐ Burial 2 📉 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci				natory`or other pla gomery rium inc		Septe	mber			
Baltimore, Maryland 21215-0036	permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service Lice			Be Be	. Name and Addr ethesda-	ess of Facility Chevy	24, Robe Chase	2006 rt A. F	wmphrey.	Fune scons	aryland ral Home/ sin Avenue
_	40 ± € 0		May 1	Sepho	1 MOO								
н			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on eac	h line.	n. Do not ent	er the mode of dy	ing, such as	cardiac or i	respiratory arre	est,	lo.	pproximate Iterval Between Inset and Death
t	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Lympho	oma					30	Months
	Examiner			Due to (or	as a conseq	uence of):							
	1 7	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated quents	b. — Due to (or	as a consequ	usries of):							
(20	outed ansit	Examiner	Cause (Disease or injury that initiated events	c									
	e exectan ar	Ex	resulting in death) Last	Due to (or	as a consequ	uence of):							
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai		_ d								_	
9	ding p	/Me	IF FEMALE:	23c. If yes, outco	me of oregon	IDCV.							
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birt	h 2 ∐ Feta ntattime of d	Ideath 3□	Ectopic pregnand Other (specify)	Э			23d. Date Monti		ay Year
o.	that the do	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow									
۳.	es that igned b be deta	by P	Part II. Other significant conditions	contributing to dea	th but not resi	ulting in the ur	nderlying cause g	iven in Part I.		23e. Did tot	oacco use contrib	ute to the	cause of death?
rds	w require been sig should b	edt								1 □ Y€	es 2 X No 3	☐ Probabl	ly 4 □Unknown
Division of Vital Records,	e law re has be je 2 sho	Completed								24a. Was a autops	n 24b. We	ere autopsy	findings available letion of cause of
Œ	The ate h page	E S								perform	nad? de	ath?	
/ita	ician: Th certificate rector. pag	Be (	25. Was case referred to medical examiner?					26. Place	of Death (	Check only on	Θ)		
<u></u>	Physician: this certific al director.	၉	1 ☐ Yes 2 ☒ No			ER/Outpatien	30 000				nce 6 □Other		
u C	or Attending Physician: titer death. Director: After this certific in by the funeral director.	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	We	ıryat ork? ∃Yes 2∐1		d. Describe ho	ow injury occurred	1	
isi	ater detend atter death Diractor: ,	Icat	2 Accident investigation 3 Suicide 6 Could not be		Finiury - At ho	me farm str				f Location (St	reet and Number	or Rural B	louis Number
<u> </u>	atter Dire	Certification:	4 Homicide determined	building	, etc. (Specify	y)	eet, factory, office		-	City or Town		0. 1.0.0.77	odio remoor,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the tuner	Medical C	29a. Certifier (Check only one)  (Check only one)	nysicien: To the bas	is of examina	wledge, death tion and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, an	d due to the call at the time, da	ause(s) and mana ate and place, an	ner as state	ed. e cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manne	Stategy		29c. Licen	se number		2	9d. Date signed (	Month, Day	y, Year)
)	0		1 /5/0	Merone	1			D0023	600		Septemb	er 22	. 2006
i	0+1		30. Name and address of poson who	completed cause	of death (Item	23а) (Туре,	Print)						, _ , , ,
_	011		Bruce R. Kresse	11, M.D.	5530 V	Viscons	sin Aven	ue #11	25 Ch	evy Cha	ase, Mar	yland	20815
	Sta Pegistr	200	31. Date filed (Month, Day, Year)	Reg	pstrar's Signa	ture							
	- anglini		SEP 2 5 200	1		(P)							

			For State Registrar	State of Mai	ryland / Dep <i>Ce</i>	ertificate of	lealth and I Death	Mental Hygid	ene 2006	30290
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Raymond Edward C	ook Sr.				2. Date of Death Month Septembe	Day Year er 18 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s Montgomery County		spital	4b. City, Town, o	r Location of Death		4c. County of Death Montgomery	
	Funeral Director			7. Age   7. Age   60	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) May 11 1	rear) Cou	place (State or Foreign intry)
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Md Howard		10c. City, Town or t Ellicott					10d. Inside City Limits 1 ☐ Yes 2√ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 3357 N. Chatham R	oad	,	10f. Zip Code 21042			g. Citizen of What Cou USA	intry?
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "neturel", or Items 23e or 28a-f ehow any injury or other traumatic event, the Madical Exertifical must be notified at ance.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Dia	, etc.
Maryland 21215-0036	id within 72 h giene. er then "netu , the Medice.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of wor		5b. Kind of Business/li	ndustry
yland	should be file ind Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last) Elroy Cook Sr.					ne (First, Middle, Ma t Rebecca		
	l and 2 she fealth and im 27 le m		19a. Informant's Name/Relationship (Ty, Raymond E. Cook Jr			Cooks Ln		tt City,	City or Town, State, Zi $MD = 21043$ Dc. Location - City or T	
Baltimore,	t. Pages I rtment of the rtant: If ite		20a. Method of Disposition  1		Garrison	ematory or other plac 1 Forest V	et. 9-27	-06 O	wings Mill:	s, MD
Ba	permit. Departrimports any inju		21. Signature of Funeral Service Licens Pay Olygot 2  23a. Part1. Enter the disease, or compli	publit	P	.0. Box 1	95 Sykes	ville, MD		Chape1
8760, 🖈	icate be executed  Medical  Examiner  physicien and string the burial-transit	dical Examiner	shock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):		g, 30011 a3 001 000	or respiratory union	4,	Interval Between Onset and Death O DIA YS
P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at till 9 □ Unknown	Fetal death 3	☐Ectopic pregnancy	,		23d. Date of deliving Month	very Day Year
ords, P	requires that een signed b nould be dete	ted by Pi	Par II. Other significant conditions cor	ute rorol	failure.	Acute De	en in Part I.	_	cco use contribute to	the cause of death? bably 4
al Rec	r: The law icete hes b		01	ondien,	(coreros	my alles	ry due	24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No F  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time	of 28c. Injur	er: 4 🗌 Nursing H	ath (Check only one, lome 5 Residen 28d. Describe how	ce 6 Other (Speci	fy)
Divis	tal or Atters after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	the Hospi nin 24 hour the Funer npletely fill	Medical	one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or	nvestigation, in my o	pinion, death occu	irred at the time, dat	se(s) and manner as e and place, and due	to the cause(s)
	To To con	~	29b. Signature and title of certifier	alnt	cun, y		6 576	!	d. Date signed (Month)	
	5+1		30. Name and address of person who co	1. M.D 10	1301 CIE	ORENA BU	E,#209	SILVED	R SORING.	HD 26902
	Sta Registi		SEP 2 5 2006	A CUST	s Signature	selle!				

State of Maryland / Department of Health and Mental Hygiene 30291 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, 2006 Year Physician SEPT. 7:07 P M CHANDLER JACK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 02/24/1914 Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Days Hours 92 216-12-6440 MD Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28e-f ehow the Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No Directo MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 BEDFORD AVENUE #414 21208 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Nyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PAPER HANGER WALLCOVERINGS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHANDLER WEINER LEWIS SARAH ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Department of Health ar Importent: If item 27 le any injury or other trau once. 1500 BEDFORD AVENUE #414 - BALTIMORE, MD 21208 RUTH CHANDLER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ANSHE EMUNAH(AITZ CHAIM) 9/22/2006 4 ☐ Donation 5 ☐ Other (Specify) HALETHORPE, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate cause (Final disease of condition resulting in death) **Physician** norths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death signed by the et d be detached for 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Yes 2 No 1 Yes 2 No : After this certification, tuneral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospitel o within 24 hours aft 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ung 1)25 205 who completed cause of death (Item 23a) (Type, Print) N. Charles St. G Boul 6701 31. Date filed (Month, Day, Year) SEP 2 5 2006 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Marylar	nd / Depa	artme	nt of Health a		ntal Hyg		2006	3029	2
	Physici	an	Hegistrar     Decedent's Name (First, Middle, La	St)		711100	ic or bodin	2	Date of Deat Month	Day	Year	3. Time of Death	A
)	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. Cit	y, Town, or Location of	Death	Splinke		County of Deatl	170 /1	
			Wirthwest	Hospital		1000	Bandalisto	win		1	altin	224	
	Funeral Director		244-30-0403	Sex 7. Age (In yrs. □ M 2 S F 8 2	last birthday) Yrs.	Month	er 1 Year If Under 2 Days Hours	Min.	Date of Birth (Month, Day, 11-31	<sup>Year)</sup> −19	Co	nplace (State or Foreig untry) _SC	n
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ty, Town or Lo	ocation						10d. Inside City Limits	3
	a-f sh	ctor	MD BALTI	MORE	MILFO	ORD						1X Yes 2 □ No	)
	vith th	Director	10e. Street and Number			10f. 2	ip Code		1	0g. Citiz	en of What Co	untry?	
	ns 234	Funeral	4012 BUCKINGHA	AM ROAD  12. Was Decedent Ever in U	J.S. 13.	Was Dec	21207	in? (Speci	ity Yes or No-	1	USA 4. Race - Ame	nican Indian,	_
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinant must be notified at ance.		1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ľ		edent of Hispanic Orig ecify Cuban, Mexican, 2 XNo Specify:	Puèrto Ri	can, etc.)		Black, White Specify:		
21215-0036	72 hou	eted	15. Decedent's E (Specify only highest gra	ducation			ual Occupation ork done during most	of working		16b. Kin	d of Business/l		
121	han "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	o. noming		C.M.		43 D.T.C	
	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Last	)	НО	USE	KEEPING  18. Mother	's Name (	First, Middle, M			MARIS	
a	Hental rked c	To Be	JIMMY BASKIN				BES	SIE	GARY				
Maryland	2 should and Men is marks aumatic		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Addre	ss (Street and Number	r or Rural I	Route Number	City or	Town, State, Z	ip Code)	- 17
	and tealth	1 3	ELLA CLAIBORNI 20a. Method of Disposition		45 Place of Dispo		PRINGDAL	E AV			IMORE ation - City or		
00	Pages nent of H int: If ite		1 Durial 2 □ Cremation 3 □	Removal from State	cemetery, cre	matory o	other place)						
Baltimore,	entme ortani injury		4 ☐Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices				AR CEM.		6-06 ES A.		TIMOR	E, MD SONS F.1	П
ä	Depe Impo any is		James C	1. meste	_		-31 LAUR	0111			IMORE		- 1
	Physician		23a. Party. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the dea one cause on each line.	th. Do not en	ter the m	ode of dying, such as o	cardiac or i	respiratory arre	est,		Approximate Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as a conse	quence of):								
П	Examiner	L	Sequentially list conditions, if any, leading to immediate	b. Dwapob	10								
	nsit	Examiner	Cause (Disease or injury	Tue to (or as a conse	derice or).								
2	be executed sicien and burial-transit		that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):								
3760,	a × a	lcal		_ d									
x 68	eath certifica attending ph for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	2001								
Вох	attend attend	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet	aldeath 3	⊒Ectopic ⊒ Other (	pregnancy specify)			23	3d. Date of deli Month	very Day Year	
о. О.	t the d by the	hys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
Records, F	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as it	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	ındəriying	cause given in Part I.			accous s 21		the cause of death?	
Ö	aw require s been si 2 should b	Completed							24a. Was a		24b. Were au	topsy findings availabl	Θ
æ	The lav	mo							autops perform	y ned? <b>X</b> No	death?	ompletion of cause of 2 No	
/ita	Ician: Sertific Sector,	Be	25. Was case referred to medical examiner?	Hospital:				of Death (	Check only on	-			
ō	Attending Physician: The Ir death. ector: After this certificate haby the funeral director, page	6	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 C	ER/Outpatier 28b. Time o		OOA Other: 4 Nur 28c. Injury at		e 5 ☐ Reside		Other (Spec	city)	
on	nding tth. : Afte e fune	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ N			,,			
Division of Vital	or At	Certification:	3 Suicide 6 Could not be determined		nome, farm, st	reet, fact	ory, office	28	f. Location (St. City or Town		Number or Ru	ral Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurre	d at the time, date and on, in my opinion, death	d place, an	d due to the call at the time, da	ause(s) a	ind manner as place, and due	stated. to the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier			2	9c. License number		2	9d. Date	signed (Month	n, Day, Year)	
)			Alila H	1si wh			H439	74	S	ipt	enter	1005.13	
	2		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	, Print)	/= ^			7	,	13 6	$\neg$
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature /	pole	V Raw	1=1157	air	40	ing lan	4	
	Registi		31. Date filed (Month, Day, Year) 5 SEP 2 5	2006	10% 16	1000	3.78				/	x .	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1106PM Debra Kar /Medical 4c. County of Death 4a. Fecility Neme (If not institution give street and number, 4b. City. Town, or Location of Death Examiner Baltmore Maryland Medical Center of University Of

5. Social Security Number Months Days Hours Min. Nov. 26, 19 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 229-27-4442 1965 Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Virginia Loudoun Purcellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36646 Shoemaker School Road U.S.A. 20132 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ģ 3 ☐ Widowed 4 🕅 Divorced White "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Technician Computer Assembley 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linyr or other traumatic event potes. 17. Father's Name (First, Middle, Last) Paul Wesley Jenkins, Sr. Earnestine Langston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Mosby Blvd. Apt. 319 Berryville, VA 22611 Earnestine Langston (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 9/25/06 Union Cemetery Leesburg, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hall Funeral Home P.O. Box 896 Purcellville, VA 20132 Mmen annis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Durk (or as a construence of): Physician cardiomyopathy unknown /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner igned by the attending physicien and be detached for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1X Yes 2 □ No 1 Tyes 25. Was case referred to medical examiner?

1 XYes 2 □ No Be 26. Place of Death (Check only one) Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other \( \) Specify 1 X Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) SGreene St Baltimore mber 31. Date filed (Month, Day, Year) SEP 2 5 State 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 30294 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:47 PM Sept Alfonzo Lee Dukes 2006 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 □ F Director 212-88-7754 43 03 18 63 MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2X No Directo Pikesville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 Painted Post Road Funeral 21208 U.S.A.

14. Race - American Indian, death 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No 11 Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 XNo Specify: Black þ 3 Widowed 4 Divorced Year or Dates: th and Mental Hygiene.
(7 is marked other than "natur traumatic event, Ita Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bobs Trucking Co. 12th grade Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental Thomas C. Dukes Minnie Bynum 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If Item 27 is or other tra 906 Painted Post Road, Pikesville, Md 21208 Minnie Dukes-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2x ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Metro Crematory Inc 9/25/06 Baltimore, Md 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Shock **Physician** 48 hours /Medical Due to (or as a consequence of): Examiner 1 Week Endo carditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Drug abuse physician and is the burial-trans Due to (or as a consequence of): Physician/Medical ettending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 28 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide n 24 hours. the Funeral Dire To the Hospital or 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the I B.P. Dave. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sept 21, 2006. BIJAL P. DAVE, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DANE

SEP 2 5 2006

31. Date filed (Month, Day, Year)

W.D.

21215-0036

Baltimore, Maryland

P.O. Box 68760,

Records,

Union

32. Registrar's Signature

Memorial Hospital, MD.

		ľ	1 - For State Registrar	State of M	aryland		artmen rtificate			and Me		giene Reg. No.	006	30295
	Physici	an	1. Decedent's Name (First, Middle,								2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Stefania Stella 4a. Fecility Name (If not institution,				45 City 1	Tour or	Lassina		PTEME		Unity of Deat	
	Examir	er	Saint Josep	h Medical	Cen	ter	4b. City,	i own, or	Location o	OWS 0	n	4c. Co	,	timore
	Funeral		5. Social Security Number 6		ge (In yrs. la	ast birthday)	If Under		If Under 2	24 Hrs. 8	8. Date of Bir (Month, Da	th V Yearl	9. Birt	hplace (State or Foreign
	Director		212-09-1932	1□M 2 <b>X</b> F	92	Yrs.	Months	Days	Hours	MIII.	07/03/	1914_		ryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl -f sho	호	Maryland Baltim	220	Coc	keysvi	110							1 ☐ Yes 2 No
	or 28a	rec	10e. Street and Number	<u>Jre</u>	· coc	velo.	10f. Zip	Code				10g. Citizer	n of What Co	ountry?
	23a c	Funeral Director	10881 York Road				210	030				Unite	d Stat	es
	teme	nuel	11. Marital Status	12. Was Decedent Armed Forces	?		Was Deced	ent of Hi rfy Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto R	ify Yes or No ican, etc.)		Race - Ame Black, White	rican Indian,
36	rs aft	Dy F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes 2	No	Specify:			Sp	pecify:	
21215-0036	within 72 hours after death with the Maryland ene. Then "neturel", or fleme 23e or 28e-f show fre Medical Exeminer mast be mullied at	Completed by	15. Decedent's	Education		16a. Deced	lent's Usua	Occupa	ation	f		16b. Kind	of Business/	lite Industry
218	ithin 7	ng l	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life.	kind of wor DO NOT us	e retired,	iuring most )	or working	9			
12	led w lygien her th	ខ	8			Seams	stress	5	40 14-4-	d- No-	Con Add date	Clot		
and	d be fi	Be	17. Father's Name (First, Middle, La	st)							(First, Middle		mame)	
Maryland	Shouk nd Me mark matik	၉	Jan Rojek  19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a			a Rowr Route Numb		own, State, 2	Zip Code)
ž	is 1 and 2 of Health a ttem 27 is other trau		Stephen C. Legg	in - Son		1606	Broad	way	Road	Luth	ervill	le. Ma	rvland	21093
altimore,	of He of Herr		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3	□Removal from State		ace of Dispo	sition (Nam	e of		Da			tion - City or	
Ĕ	Pag ment tent: i		4 □ Donation 5 □ Other (Spe	cify)	Hol	y Rosa	ary Ce	emete	ery	09/26	/2006	Balti	more,	Maryland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Deperment if them 27 is marked other than "naturelt, or theme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be rivillised at once.		21. Signature of Funeral Service Lie	censee	AFS	D D2	Name and	Addres J. We	s of Facility eber	Funer	al Hon	nes P.	A.	
			23a. Part1. Enter the disease, or co	omplications that cause	d the death								, Mary	land 21231
	Marainian		shock, or heart failure. List or Immediate Cause (Final	lly one cause on each I	ine.									Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. ACUTE  Due to (or as			HEST	TIMH	L BL	EED				1 HOUR
	Examiner		Sequentially list conditions.	b										
1.	sit ad	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence or):								
to	xecuti and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):								
8760,	cate be executed physicien and the burial-transit			d										
9	ufficat ng phy as th	Physician/Medical		0.										
Вох	ath cer tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	egnancy				23d	f. Date of deli Month	ivery Day Year
P.O.	the el	yslcl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	t time of de	eath 5□	Other (spe	ecity)					MORITI	Day 16ai
	law requires that the death certific as been signed by the ettending pl 2 should be detached for use as t		Part II. Other significant condition	s contributing to death I	out not resu	iting in the u	nderlying ca	use give	en in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
ds	turres n sign ald be	d by									10	Yes 2□N	No 3□Pr	obably 4 Unknown
ဝ	aw rec	plete									24a. Was	an 2	4b. Were au	topsy findings available
<u>~</u>	Ihe lav ate has page 2	Completed									auto perfo 1 Tyes	ormed?	death?	
/ita	clan: ertifici actor,	Be	25. Was case referred to medical examiner?		1	,				of Death (	Check only	-		
of o	Physician: rthis certifica ral director, i	2	1 ☐ Yes 2 ☐ No 27. Manner of Lath	Hospital: 1 ☐ Inpati	40	P/Outpatien		<del></del>	4 🗆 1401		e 5 ☐ Resi			cify)
0	ding th. After tuner	tlon	1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	Bc. Injury Work 1 □ Y	rai ? Yes 2∐N		3d. Describe	now injury o	ccurred	
Division of Vital Records,	Attending r death. ector: Alter by the fune	Ifica	3 Suicide 6 Could no	t be 28e. Place of In	jury - At ho	me, farm, str					3f. Location (	Street and N	lumber or Ru	ural Route Number,
ā	rs after or re rs after or rs after or rs after or rs after or rs after or rs after or rs after or rs after or rs after or rs after or rs after or rs after or rs after or re re rs after or re rs after or re rs after or re re rs after or re rs after or re rs after or re rs after or re rs after or re rs after or re rs after or re re rs after or re rs after or re rs aft	Certification;	4   Homicide	building, e	tc. (Specify	,					City or To	wn, State)		
1	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examinati	viedge, death ion and/or inv	occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, an	nd due to the d at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier	mobal 1	~ W,	asn.	29c	License	number			29d. Date s	igned (Montl	h, Day, Year)
	1.1		Ben	180 P. J.	Bays			D 3	1674			9/2	22/06	
	M			no completed cause of			•	gray, sar a r	1000 mm	E 9,000 ann a -	4.4	1	Me. am	
	Sta	te	JEFF BERNSTE 31. Date filed (Month, Day, Year)		rar's Signat	nte <sup>n</sup>	EK D	KIV	E 10	NUEW	, MAR	YLANI	0 212	V/4
	Registr	-	SEP 25	2006	GLASIA .	ure List A	ORALL.	<i>y</i>						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 30296 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day **Physician** 16:44 M SEPTEMBER 19 MARGARET 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE CITY THE JOHNS HOPKING HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. May 21, 1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 21X0 F 249-72-3149 62 Yrs. South Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Columbia Howard Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or iteme 23a or 10400 Swift Stream Place Apt. 106 21044 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Editor Education es 1 end 2 should be filed w of Health and Mental Hygiei I Item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Arthur Reagan, Jr. Katherine Tillotson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 st.
Department of Health and
Important: if Item 27 is m
eny Injury or other traum Marshall O. Donley, Jr.-Husband 10400 Swift Stream Place Apt. 106 Columbioa, MD 21044 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Riverview Cemetery 9-23-2006 4 ☐Donation 5 ☐Other (Specify) Lancaster, PA Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service Licensee Welstell Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiovascular gon (01/4P3e /Medical Due to (or as a consequence of): Examiner Sepsis

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physicien and hed for use as the burial-transit Liver transplant
Due to (or as a consequence of): 15 years Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month detached for Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown sete has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificete has autopsy performed? 1 Yes 2 No tal or Attending Physician: Tre after death.

It Director: After this certificet ed in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 18 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Box 68760. P.O. | Records, Division of Vital To the Hospital or Atte within 24 hours after der To the Funerel Directo completely filled in by th

> State Registrar

TRACY WANNER, JOHNS HORLINS HOSPITHS, GOD NORTH WOLFE STREET, BALTIMORE MD 21287
31. Date liled (Month, Day, Year)
32. Philistra's Signature

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

SEPTEMBER 19, 2006

SEP 2 5 2006

29b. Signature and title of certifier

Tracy

Wanner, MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (Firşt, Middle, Last) st Year Day 21 2006 Dash Septenker **Physician** Else 11:15am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hosp Columbe Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Director 214-22-8695 79 Feb. 26,1927 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County r than "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2205 Edmondson Avenue 21228 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23€ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 25CNNo Specify: 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Account Manager Customs Brokerage permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 is marked other tt any hiury or other traumatic event, III.a 2002. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stephen K. Uchuck Mary Socha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2205 Edmondson Avenue; Catonsville, MD 21228 Joseph Dash Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State St. 9-25-2006 Baltimore, Maryland Stanislaus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. uneral Service Licens e 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) isproatom neunoma Physician /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last equence of) Examiner attending physicien and for use as the burial-transit that the death certificate be executed 1 Due to (or as a consequence of): aptical outhough Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 【No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, law requires 1 ☐ Yes 2 AÑo 3 Probably 4 Unknown been sign 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy certificete 2 No 1 Yes 2 No 1 Yes Vital Be director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 2 ER/Outpatient 3 DOA of this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: Division or Attending 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) To the 29b. Signature and title of cenitier 29c. License number 29d. Date signed (Month, Day, Year) D50870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clarksulle MD lane 005 Signal Bell bdo 5420m 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 5 2006

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artment of He tificate of D	ealth and Death	Mental Hyg	giene 1eg. No. 2 (	106	30298
1 1 3	1	1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death
Physic /Medi		Rita A. Etheric	lge					Septemb		2006	10:15 P <sup>M</sup>
Exami		4a. Facility Name (If not institution		imber)		4b. City, Town, or	Location of Dea	th	4c. Count	of Death	
		5916 Rustic Lar		T = 4		Elkridge			Howa		
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	r, Year)	Coun	
Director		220-30-4691 Usual Residence of Decedent		72				05/26/1	934	Mary	Tand
yland Now		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
Mar	ţċ	Maryland Howard	3	Elkı	ridge						1 Yes 2 No
th the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
death with the Maryland me 23a or 28a-f ahow r muat ter nyllited at		5916 Rustic Lar	ie			21075			United	State	s
r des	Funerai	11. Marital Status	Armed F			Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ce - Americ ck, White,	
s afte	by Fi	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 Tes If Yes, G Year or I	2 No live		1 ☐ Yes 2 No	Specify:		Speci		
IIIQ Z I Z I 3-0030 be filed within 72 hours after tal Hygiene. d other than "natural", or fre event, tre Medical Exercise.		15. Decedent		Dates.	16a. Dece	dent's Usual Occupa	tion		16b. Kind of E	Whi Jusiness/Inc	
in 72	Completed	(Specify only highes	t grade completed,		(Give	kind of work done di DO NOT use retired)	uring most of wo	orking			,
yiene.	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)	Homen	aker		/	Domest	ic	
d be filed antal Hyg sed other	BeC	17. Father's Name (First, Middle, I	ast)				18. Mother's Na	me (First, Middle,			
	10	Joseph W. Cheri	v				Anna Sa	boy			
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a	nd Number or R	Rural Route Numbe	r, City or Town	, State, Zip	Code)
e, IN 1 and 2 Health 16m 27		Katherine Ether	.dge - Da	ughter	7834	Old Farm	Lane El		ity, Ma	rylan	d 21043
Pages 1 nent of H; int: If Iter		20a. Method of Disposition  1 Durial 2 Cremation	3 Removal from		lace of Dispo emetery, crer	sition (Name of natory or other place	)	Date	20c. Location	- City or To	wn, State
Pag tmeni tant: jury		4 Donation 5 Other (Sp	pecify)			Crematory		25/2006	Baltimo	re, M	aryland
DEMILITIONE, I permit. Pages 1 an Depertment of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service I	icer(see		Da	Name and Address Vid J. We	eber fun	eral Hom	es P.A.		
40260		23a. Part1. Enter the disease or	/////	acused the deet	53	311 Edmond	lson_Ave	nue Balt	imore,	Maryl	and 21229 Approximate
	- 1	shock, or heart failure. List	only one cause on	each line.				_			Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				OF SPHE	NOID +	ETHMOID	SINUS	E-S	6 MONTHS
Examiner			Due to	o (or as a conseq	uence of):						
*	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):						
uted d ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events									
be executed ician and burial-transit	Exa	resulting in death) Last	Due to	(or as a conseq	uence of):						
of ou, cate be executed obysician and the burial-transit	dicai	1	d								
THECOTOS, P.O. BOX 08/ The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the		IF FEMALE:				-					
DOX lath cer attendir for use	an/I	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 🗆 Feta	I death 3	Ectopic pregnancy	^	VIA		ate of delive	ry Day Year
the deached	Physician/Me	1 Yes 2 No	4☐Preg 9☐Unki	mant at time of d	leath 5	Other (specify)				51111	100.
hat th		Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlying cause give	n in Part I	23e. Did to	bacco use con	tribute to th	e cause of death?
Signe signe	Completed by	DEGENERATIVE					ISEASE	1 🗆 Y	14	3 Prob	
HECOLOS, he law requires t a has been signe ige 2 should be o	etec	D CQ CTOCKTTTTO			200120115			24a. Was	245	Moss suts	an finding and lable
ne lav	lg m							autop	sy	prior to cor death?	psy findings available inpletion of cause of
VICAN I	ပို	25. Was case referred to medical					00 81 (8		2□ No	1 🗌 Yes	2X No
S cert	00	examiner?	Hospital:	Inpatient 2	ER/Outpatier	t 3 DOA Othe	-	Home 5 Resid		nor (Specif	4
DIVISION OI  I or Attending Phy after death. Director: After this in by the funeral d	n: To	27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time of			28d. Describe h			<u>'</u>
nding ath. P fun	atio	1 Natural 5 Pendin 2 Accident investig	9	nin, Day rear)	Injury		? ′es 2 □No				
VIS Afte er de by th	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ot be 28e. Plac	se of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		ber or Rura	I Route Number,
rs after safter all Die	Certification:							0.1, 0.			
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompietely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical	Examiner: On the	basis of examina		n occurred at the tim vestigation, in my op					
thin 2 the the mplet	Med	29b. Signature and title of certifier		nner stated.		29c. License	number		29d. Date sign	ed (Month	Day, Year)
F 2 5 8		A. A				*	2202		001	-61	
2		30. Name and address of person	who completed car	use of death /lt	n 23a) /Tuna		4483	2	- 7/	25/	2006
	and a second	Soun JA KII	M. M. A	580	8 MA 1	USTREET	ELKE	IDGE, M	D 21	7.5	
Si	ate	31. Date filed (Month, Day, Year)	- 32.	Registrar's Signa	ature /		/ ==			10	
Regist		SEP 2.5.20	06 Blee	e B.	GOSA						

Registrar

SEPTEMBER

EDWARD ELLIOTT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2006

		•	1 - For State Registrar	,, ,, ,	Cer	tificate of	Death	F	Reg. No.	700	00000
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici: /Medic			Marthajane F	uss			Septeml	-		6:50 PM M
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. Cily, Town, o	or Location of Dear	th	4c. County	of Death	
				Chevy Chase			Chevy Cha			Montgo	
1	Funeral			Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da)	h y, Year)		ce (State or Foreign y)
	Director		577-46-9872 Usual Residence of Decedent	85	113.			April 2	25, 1921	Penn	sylvania
land	Mo II		10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				100	d. Inside City Limits
Mary	- E E	ō	D.C.			T.I	Jashingto	M			1∭Yes 2□No
the	728a	Director	10e. Street and Number			10f. Zip Code	asiiingcc		10g. Citizen of V	What Countr	y?
h with	38 o		5412 31st	Street N.W.			20015		Un	ited (	States
deat	am 3	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of H		Specify Yes or No- to Rican, etc.)		e - American	n Indian,
after a	or Ite	正	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No It Yes, Give		☐ Yes 2 No		to ritoan, etc.)	Specify	ck, White, etc.	C.
)03	Exa	d by	3 X Widowed 4 □ Divorced	Year or Dates:		2,100	оросну.		Зреспу	Wh	nite
<b>21215-0036</b> d within 72 hours aft	it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f ehow or other traumatic event, the Medical Examinal must be notified at	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Give I	ent's Usual Occup kind of work done	during most of wo	orking	16b. Kind of Bu	usiness/Indu	istry
<b>12</b>	than	dw	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	,		of Dom	Leagu	
2 P	Hygie ther nt, tr		17. Father's Name (First, Middle, Las	st)	Ex	ecutive		me (First, Middle,			ian Women
and	od o	Be c		onald Keff <b>e</b> r				,			
Maryland d 2 should be file	d Me mark matic	요	19a. Informant's Name/Relationship		19b Mailin	a Address (Street	and Number or R	ural Route Numbe	a O'Con		Code)
Na d 2 s	th an		David A. Fuss/					.W. Wash			
re, N	Hea tem other		20a. Method of Disposition	20b F	Place of Dispos	sition /Name of		Date Wasii	20c. Location -		
Baltimore,	Department of Health a Important: If Item 27 is any Injury or other tra		1  Burial 2  Cremation 3 4  Donation 5  Other (Spec	□Removal from State	Gemetery, crem	atory or other place	Sep	tember	041 (	3 <b>:</b>	W1 1
# # #	artme ortar Injur	-	21. Signature of Funeral Service Lice	- 01	neave:	n Cemeter Name and Addre	ss of Facility RO	, 2006  : bert A.	Silver S Pumphre	spring v Fune	, Maryland eral Home/
Balt permit.	Depa Impo any Ir		100	MO0:	335 Be	thesda-C	hevy Cha Marvland	se Inc.	7557 W	iscons	eral Home/ sin Avenue
			23a. Part1. Enter the disease, or co	mplications that caused the deat						A	Approximate
Ph	nysician		shock, or heart failure. List on Immediate Cause (Final	y one cause on each line.	· 100	· · · · ·	11			l c	nterval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a conseq		hodeh	w can	Cer			
E	xaminer										
	-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence of):				-		
Cute	ransi	Examiner	mat initiated events	c							
, o	ien al urial-t		resulting in death) Last	Due to (or as a conseq	quence of):						
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed	physicien and s the burial-transit	Medical	•	d							
x 6	ling p	Mec	IF FEMALE:								
Box eath ce	attendi for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. It yes, outcome of pregna 1☐Live birth 2☐Feta	al death 3 🗌	Ectopic pregnancy	у		23d. Dat	te of delivery nth D	/ Pay Year
O 8	the a	Physician/	1 ☐ Yes 2 MNo 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	death 5∐	Other (specify) _					,
D tat	ed by the detached		Part II. Other significant conditions	contributing to death but not res	sulting in the un	iderlying cause giv	ven in Part I	23e. Did to	bacco use conti	ribute to the	cause of death?
Division of Vital Records, P.O	signed d be det	d by		<b>3</b>	<b>3 2</b>	,, 5					oly 4 ⊠Unknown
JO.	been s should	ete									
3e a	has 3e 2 :	Completed						24a. Was autop	an 246. v sy p med? c	were autops prior to comp death?	y findings available pletion of cause of
<u>_</u> = =	certificete rector, pag							1 ☐ Yes	2,12(No 1	I ☐ Yes 2	□ No
Vit	certi	Be c	25. Was case reterred to medical examiner?	Hospital:	1500	Oth	100	ath (Check only or			
P. O.	r this ral di	7: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3 DON	4 per intri siring i	Home 5 ☐ Resid	lence 6 ∐Othi		
O D	th. : After funer	ţ	1 √Natural 5 ☐ Pending 2 ☐ Accident investigati		Injury		rk? Yes 2∐No		. ,		
/isi	after death Director: /	Hica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At he	ome, tarm, stre	et, factory, office			treet and Numb	er or Rural F	Poute Number,
	Direction of the control of the cont	Certification:	4  Homicide determine	building, etc. (Specif	fy)			City or Tow	m, State)		
ple	hours neca y fille		29a. Certifier 1 🗵 Certifying F	Physicien: To the best of my kno	owledge, death	occurred at the tir	me, date and plac	e, and due to the o	ause(s) and ma	nner as stat	ed.
¥	within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Expone)	aminer: On the basis of examina and manner stated.	ation and/or inv	estigation, in my o	pinion, death occ	urred at the time, o	date and place, a	and due to th	he cause(s)
 10 #	To ti	Σ	29b. Signature and title of certifier	2950		29c. Licens			29d. Date signed	d (Month, De	ey, Year)
	n		<i>b</i>	-		D00	54766		9/2010	6	
_	10		30. Name and address of person wh	completed cause of death (Iter	m 23a) (Type, i	Print)					
			Such and address of person with Such and Abord	zeili, 1220 A 8	Fort or	Ofa Roc	o, sui	4230 TC	Lesopo	HDZ	1286
	Sta Registr		31. Date filed (Month, Day, Year) CED 9 5 7	objection of digital	ature	Sec.		/			

State of Maryland / Department of Health and Mental Hygiene 2005 30301 1 - For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 20, 2006 4:30 P M Edward **Physician** Filar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6180 Old Washington Road Elkridge Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F 220-01-5060 87 Director MD Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ehow 1 ☐ Yes 2 ☑ No Director Howard Elkridae 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "neturel", or iteme 23a or the Medical Examiner must be r 6180 Old Washington Road 21075 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) Railroad Maintenance B & O Railroad Pages 1 end 2 should be filed w timent of Heelth and Mentel Hygier tant: if item 27 is marked other it ijury or other treumatic event, the 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanislaus Filar Kazimiera Klamut 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Byerly Niece 5125 South Rolling Rd., Relay, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation S ☐ Other (Specify) Metro Crematory 09/25/2006 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, TNC.
7250 Washington Blvd., Elkridge, MD 21075 M01378 7250 Washington Blvd., Elkric 23 Part. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01378 Approximate Interval Between Onset and Death Immediate Cause (Final heart **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Atheroscleration Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physicien and for use es the burial-trans Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of defivery 3 ☐Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificete has blirector, page 2 s autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. fnjury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours e To the Funerei I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D26256 9/22/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BICH DUDNG, MD 724 Marclen choice Cane Baltimore MD 21228 DUONG, MG 31. Date filed (Month, Dey, Year) 32. Pegistrar's Signature State Sparte Registrar 2 5 2006

State of Maryland / Department of Health and Mental Hygiene 2006 30302 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEFMEMBER° 22, 2006 **Physician** 08:20AM Michael T. Gerapetritis /Medical 4b. City, Town, or Location of Death 4c. County of Death, Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 18, 1942 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 □ F 64 Greece 217-40-6158 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland II Hygiene.
other than "natural", or Iteme 23a or 28a-f ehow 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts ir than "natural", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director MD Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 409 Fox Chapel Drive Greece 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Michael's Steak & College (1-4or 5+) Elementary/Secondary (0-12) Lobster House 0wner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny july or other treumatic event 2008. Be Panagiota Sakelis Themistocles Gerapetritis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 409 Fox Chapel Drive; Timonium, MD 21093 Fotini Gerapetritis wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Oremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/26/06 Oak Lawn Cemetery Dundalk, MD Dither (Specify) 21. Signature of Fune of Service Licenses 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Betweer Enset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician /Medical Due to (or as a consequence of):
METASTATIC CARCINOMA OF NASOPHARYNX 1 YEAR Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physicien and be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown **D90** 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 **X**No 1 Yes 21 No this certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 1] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number mehla Seftenhin 22 D41420 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 JOGINDER MEHTA, M. D. 7601 OSLER DRIVE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			1 - State Registrar	State of Maryland		nent of H			eg. No. 200	6 30303
ı	Physici /Medic		1. Decedent's Name (First, Middle, Las	Grriffin				2. Date of Dear Month	th Day Yea 23 200	
)	Examin		4a. Facility Name (If not institution, give	Circoter laws	el	Lau	Location of Death		4c. County of De	Path 2 George
	Funeral Director		5. Social Security Number  443 -22-3274  Usual Residence of Decedent	7. Age (In yrs. las		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day,	929 O	Sirthplace (State or Foreign Country)
	death with the Maryland ms 23a or 28s-f show const be notified at	tor	10a. State 10b. County  Add Rince	(CODERS) 10c. City,	Town or Location	larlbo	ro			10d. Inside City Limits 1 Tes 2 No
	th with the 23a or 284	ai Director	10e. Street and Number	ive		0f. Zip Code 207	74	1	Og. Citizen of What	Country?
0036	n 72 hours after death with the Marylar "natural", or Items 23a or 28a-f show edical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of His s, specify Cubar Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: 3	. = -
)0-CLZI		Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or 5+)	LI III DO N	of work done di NOT use retired)	uring most of wor	king	16b. Kind of Busines	
and 2	be filed ital Hygi id other avent.	To Be Co	17. Father's Name (First, Middle, Last)  Alex Griffin	<u> </u>	red, co	1 /20	hnologi 18. Mother's Nam Mattie	e (First, Middle, I	Maiden Sumame)	nmanT
, mary	ges 1 and 2 should t of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (1) Christa Griffin	ype, Print)	19b. Mailing Ad	ddress (Street a			City or Town, State	Zip Code)
baitimore	t. Pages 1: rtment of He rtant: If Itan		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State		ry or other place	des 9-30	- 2001	20c. Location - City of	Klahoma
<u>R</u>	permit. Pag Depertment Important: any Injury once.		21. Signature of Funeral Service Licen	. Doufan	- 170	1 Mc Cu		- Sal	ral Servi	led.
j.	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. <u>Cavdiv va</u>	culon		elent	due to		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Prostourc  Due to (or as a consequence)	Car	ica				
oo,	ficate be executed  physicien and ts the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequen	nce of);					
navea xoc	death certificate be e ettending physicie od for use as the bur	/Medical	IF FEMALE: 23b. Was decedent pregnant	d	:y				23d. Date of d	elivery
j O	it the death by the ette tached for	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown		opic pregnancy ner (specify)			Month	Day Year
cords, r	The law requires that the destete has been signed by the page 2 should be detached	þ	Part II. Other significant conditions co	ontributing to death but not resulti	ing in the under	ying cause give	n in Part I.			to the cause of death?  Probably 4 (4 (4 (1) known)
nec	: The law ricete has be	Completed						24a. Was au autops perform 1 Yes 2	y prior to ned? death?	autopsy findings available o completion of cause of ess 2 No
	nysician: Th nis certificete director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ② No	Hospital: 1 ☐ Inpatient 2 ☐ EF	NOutpatient 3	□ DOA Othe		h <i>Check</i> only one	ence 6 ☐Other (Sp	necify)
DIVISION OF	anding Pt eath. or: After th	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	(Month, Day Year)	8b. Time of Injury	28c. Injury Work 1 □ Y			ow injury occurred	
Ž	To the Hospitel or Attending Physicien: within 24 hours after dealth at 10 the Funeral Director. After this certifical cumpletely filled in by the funeral director.		3 Suicide 6 Could not be determined	building, etc. (Specify)				City or Town		
	ha Hosp in 24 ho ha Fune pletely f	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Examone)	ysician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death occ n and/or investig	gation, in my opi	e, date and place, nion, death occur	and due to the ca	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	tot Tot E	Σ	29b. Signature and Atle of certifier	mD		29c. License	number 065374		9d. Date signed (Mor	nth, Day, Year)
	10		30. Name and address of person who o	completed cause of death (Item 2	3a) (Type, Print	)		0=-	# 210 &	Burile MID
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 5 2006	32. Registrar's Signatur	And I	A- Fux	e lane	>/E	# 210 2	26715

			For State Registrer		State of Ma	aryland		tificate				Reg. N		30301	+
	Physici /Medic		1. Decedent's Name ( Adrienne		n						2. Date of D Month Septe		<sup>2</sup> 2000	3. Time of Death 6 2:15 a M	
0	Examin		4a. Facility Name (If no Upper Ches			enter			rown, or	r Location of De Air	eath	4	c. County of Death Harfor		
	Funeral Director		5. Social Security Nur 090-07-3	mber 6. Sex	7. Ag		st birthday) Yrs.	If Under Months		If Under 24 H	in. 8. Date of E (Month, I	Da <i>y</i> , Yea	9. Birth Co. 107 Ho1	nplace (State or Foreign untry) Land	
	land w		Usual Residence of D	Decedent 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	_
	deeth with the Maryland ms 23s or 28s-1 show rmust be notified at	ctor	Md.	Harford				Joppa	L .			,		1 ☐ Yes 2 🛣 No	
	with the	Director	10e. Street and Numb					10f. Zip		085		10g. C	Ditizen of What Co	intry?	
	deeth	Funeral	519 Newber		2. Was Decedent Armed Forces?	Ever in U.S	6. 13.	Was Deced			(Specify Yes or I	No-	14. Race - Ame Black, White		_
936	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Depertment of Heath and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Items 23a or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at Once.	by	1 Never Married 3 Widowed 4	d 2/21/Married	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		1 ☐ Yes 2		Specify:	erto Moarr, etc.)		Specify: wh		
25	n 72 ho "netui edical	Completed	(Specify	5. Decedent's Educ only highest grade	completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occup	ation during most of t	working	16b.	Kind of Business/	ndustry	
7(5	d withi	omo	8 years	dary (0-12)	College (1-4or !	5+)		maker					own hom	e	
0 o pu	be file ata! Hy od othe	Be	17. Father's Name (F								Name (First, Midd	lle, Maide	en Sumame)		
aryle	should nd Mer marke imatic	ပို	Klaas Eve		эе, Print)		19b. Maili	ng Address	(Street		nown Rural Route Num	ber, City	y or Town, State, 2	ïp Code)	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	and 2 saith a n 27 is		Jan Gladd		d	1					Joppa,				
) Journal	ages 1 ant of Hu it. if iter y or oth		20a. Method of Dispo	osition  Cremation 3 □R 5 □Other (Specify)	emoval from State		ace of Dispo nmetery, crei view (				Date 20/06		Location - City or		1
$g/\iota_{\ell}/_{\ell}$ $\ell$ 0245 $a_{\ell}$ Baltimore, Maryland 21215-003	Depertme Depertme Importan any injur	3	21. Signature of Fun			Bay		Schim	d Addre	ss of Facility k Funer	al Home	of B	Bel Air,		
			23a. Part1. Enter the shock, or heart	disease, or compli	cations that caused	d the death	. Do not ent	610 W er the mode	M e of dyin	acPhail ng, such as card	Road, B	e1 A	ir, Md.	21014 Approximate Interval Between	$\exists$
	Physician		tmmediate Cause (F disease or condition	inal	Sep	515	5							Onset and Death	
	/Medical Examiner		resulting in death)		Due to (# as	a consequ	ience of):	art	30	fecti	กท				
0	φ #	Iner	if any, leading to immorause. Enter Underly Cause (Disease or in	nediate ying	Due to (or as	a consequ		ци	101	TECH					
OB	execute n end al-trans	Examiner	Cause (Disease or in that initiated events resulting in death) La	- C	Due to (or as	a consequ	ience of):								-
05/	ificate be executed g physicien end as the burial-transit	edical			l		·								_
S × 6	= 0,00	n/Med	IF FEMALE: 23b. Was decedent	pregnant 2	3c. If yes, outcome			75					23d. Date of deli	very	
A.G.	w requires that the death cert been signed by the ettendin should be deteched for use	Physician/M	in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	ponths? No	4⊟Pregnant a 9⊟ Unknown			Ectopic pro Other (sp		,		-	Month	Day Year	İ
, d.	is that t gned by		Part II. Other signific	-1	1 ,	1.		1 '		14		d tobacc	o use contribute to	the cause of death?	
of disp	require	eted t	Severe		cobstr	udi	repu	umo	nar	ydisa			2 No 3 Pr		
Adrien Becords, P.	To the Hospitel or Attending Physician: The law within 24 hours effer death. To the Funaral Director: After this certificate has E completely filled in by the funeral director, page 2 s	Completed by	Severe	, dem	entio	ب					_ 24a. Wh au pe 1 ☐ Yes	topsy riormed2	? death?	topsy findings available completion of cause of 2 No	
ZE S	sician certifi irector	Be	25. Was case referre examiner?	-	lospital: Inpati	ont 2 🗆 1	ER/Outpatie	nt 3[] D0	Ott	000	Death Check onl		6 □Other (Spec	2.6.1	-
n of Vital	ing Phy Mer this uneral d	n: To	1 Yes 2 N 27. Manner of Death 1 Natural		28a. Date of Inju		28b. Time o		8c. Injui	ry at			link occurred	ny)	-
Sion	ttendir death. ctor: Af r the fu	Certification:	2 Accident	investigation 6 Could not be	28e. Place of In			M feet factory		Yes 2 □No	28f. Location	(Street	and Number or Ru	ral Route Number	4
35	s efter al Direct	Certif	4 🗍 Homicide	determined		tc. (Specify		oot, ladioly	, 00		City or	Fown, Sta	afe)		
9	Hospitel     24 hours e     Funarai C     letely filled	Medical	29a. Certifier (Check only one)	Certifying Phys	sicien: To the best ner: On the basis of and manner st	of examinat	wledge, deat tion and/or in	h occurred vestigation	at the til	me, date and pl opinion, death o	ace, and due to the courred at the time	ne cause e, date a	(s) and manner as and place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and t	itle of certifier				290	c. Licens	se number		29d. [	Date signed (Monti	n, Dey, Year)	
			1 9 or	55	<i>p</i>	4-14-4	00-1-07		D-3	2257		Se	ptembe	r/6,200	9
	2		30. Name and addre	ss of person who co	mpleted cause of	5_W	/. (Type,	acp	ha	I B	eldic	N	10 210	014	
	Sta Regist	ate	31. Date filed (Month		32. Regist	rar's Signa	ture,	docul	No.						

8454ん

Granco

MARNO

State of Maryland / Department of Health and Mental Hygiene200630305 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Sept. 22, Eduardo Genco 8:45p 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 305 South High Street n/a Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 1 XM 2 ☐ F 48 Yrs. 217-70-0695 10-13-1957 Baltimore, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Yes 2 No Baltimore Director n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21202 305 South High Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Supervisor permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Importent: If item 27 Is marked other t any injury or other treumatic event. The once. 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Giuseppa DiGirolamo Giuseppe Genco 19a. Informant's Name/Relationship (Type, Print) friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 824 S. Luzerne Ave., Baltimore, Maryland David Ratajczak 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/26/2006 Baltimore, MD Oaklawn \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. FH Maria 263 S. Conkling St.Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastaticu Physician 5 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter the Jordan Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred el or Attending P s after death. Il Director: After in id in by the funera 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier D0063449 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore 4940 Heather some 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

SEP 2 5 2006

August   Department   Company   Co				1 - For State Registrar	State	of Marylar	nd / Depa	artmer rtifica	nt of H	ealth a Death	ind M		iene2	006	30306
Second Second Policy   Second Policy   Second Second Policy   Second Policy	8											Month	Day		
Direction    Control   Con				12510 Epping Co	ourt			Whe	aton				Mor	itgome	ry
To Sile   100 County   100 Force Orly From or Location   100 Force Orly From Orl Location   100 Force Orly From Orl Location   100 Force Orly From Orl Location   100 Force Orly From Orl Location   100 Force Orly From Orl Location   100 Force Orl	•			223-40-0092							Min.	(Month, Day	, Year)	Cou	intry)
Search only righted and completed   Search only righted and completed   Search only righted and completed   Search only righted and completed   Search only righted and completed   Search only righted and completed   Search only righted and completed   Search only righted   Search onl	36	s after death with the Maryland , or Items 23e or 28e-f show our contines by multiles at	y Funeral Director	10a. State 10b. County  Maryland Montgo  10e. Street and Number  12510 Epping Co  11. Marital Status  1 □ Never Married 2♥ Mare	omery  Ourt  12. Was Der Armed F 1   Yes	Whe	J.S. 13.	10f. Zi 20 Was Dece If Yes, spe	906 Ident of Hi acify Cuba		gin? (Spe , Puerto F		U.S.	of What Cou	1 ☐ Yes 2 ☒ No intry? ican Indian, , etc.
Doseph Brooks  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Rule Number. City or Town, State, Zip Code)  Johnnie D. Hardison (Husband)  12510 Eprine Ct., Wheaton, MD 20906  20b. Place of Deposition (Name of Control Print)  20b. Place of Deposition	7721	ed within 72 hour yglene. her than "natural it, the Medical Ex		15. Deceden (Specify only highe Elementary/Secondary (0-12) 12	t's Education st grade completed College	)	(Give life.	kind of w DO NOT L	ork done d ise retired	during most nent			16b. Kind o	f Business/li Meyer	
Source   S	Maryiand		Be	Joseph Brooks 19a. Informant's Name/Relations	hip (Type, Print)					Rebe	ecca or Rura	Woodfo] I Route Number	Lk , City or To	wn, State, Zi	p Code)
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate interval Belower flower and Death Medical Examiner  Physician Medical Examiner  The death of the part of the mode of the part of the mode of the part of	αĵ	it. Pages 1 and rtment of Health rtent: If item 27 njury or other t		20a. Method of Disposition  1X Burial 2 Cremation 4 Dopation 5 Other (S	3 □Removal from Specify)	20b. State	Place of Dispo cemetery, crei antico	osition (Na matory or Nat.	me of other place	etery	9/:	ate	20c. Locatio	on - City or T	
Due to (or as a consequence of):    Continue	Ba	Depa Impo sny i		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that only one cause on	each line.	ith. Do not ent	Baile L207 ter the mo	y Fur White de <i>o</i> f dying	neral e St. g, such as	Serv Fre	edericks respiratory arr	est,		Approximate Interval Between
23.0. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   1   Yes 2   No 3   Probably 4   Un	the state of	/Medical Examiner  hysicien and perinal-transit	Icai	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	quence of):	~->1	nai	l Cel		ng ca	ncer		112 years
We cause given in Part I.    Continuous   Co	O. BOX	death e atter	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1☐Live 4☐Preg	birth 2 ☐ Fet nant at time of	aldeath 3[						1		,
25. Was case referred to medical examiner?  1   Yes   2   No   No    1   Yes   2   No    27. Manner of Death   1   No    1   Yes   2   No    28a. Date of Injury   28b. Time of		requires that een signed b nould be deta	by				sulting in the u	nderlying	cause give	en in Part I.					
1   Yes   2 M No   1   Inpatient   2   ER/Outpatient   3   DOA   4   Nursing Home   5   Residence   6   Other (Specify)    27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28d. Injury at Work?   1   Yes   2   No    28d. Describe how injury occurred   28d. Describe	r											autops perfori 1 Yes	med? 2 X No	prior to co death?	ompletion of cause of
29a, Certifier 1X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated		nding Physicia ath. rr: After this certi he funeral directo	ToB	examiner? 1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pendir	Hospital: 1 = 28a. Date (Mo		28b. Time o	f	28c. Injury Work	er: 4 □ Nui ⁄at c?	rsing Hom	ne 5 🕅 Reside	ence 6 🗆 (		rfy)
State   Stat	DIVIS		O	4 Homicide determ  29a. Certifier 1 Certifyin	build build	ding, etc. (Special	owledge, deat	h occurred	at the tim	ne, date and	d place, a	City or Town	n, State)	manner as	stated
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  David C - Van Echo, MD 6900 Georgia Ave Nw Washington DC 20307  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	•	To the Ho	Medic	29b. Signature and title of certifie	Exeminer: On the and ma	basis of examin nner stated.	ation and/or in	vestigation 29	n, in my op	oinion, deat	th occurre	ed at the time, d	ate and place  9d. Date sig	ned (Month)	to the cause(s)  Day, Year)
TO A PROPERTY AND A P	25			David C. Va	who completed can m Echs	Registrar's Sign	m 23a) (Type,	Print)	seorg	ia A	re 1	In u	iash:	ngton	DC 20307

State of Maryland / Department of Health and Mental Hygiene 2005 30307 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** otember 20.2006 Phyllis C. Haluch /Medical 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE Saint AGNES HOSPITAL

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Director 79 Maryland 215-22-1320 01/18/1927 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "naturel", or Iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 1234 Pleasant Valley Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic Department of Heelth and Ameria Pages 1 and 2 should be filed.
Department of Heelth and Mental Properties of Heelth and Mental Properties of the Page 1 and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Phillip Charles Newberry Catherine Gannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Haluch - Husband 1234 Pleasant Valley Drive Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/25/2006 Baltimore, Maryland 21. Signatur of Funeral Service Licedsee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** isthemic vascular rerebrat 5 min /Medical Due to (or as a consequence of): Examiner arrhythmia Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien and the buriel-transit Due to (or as a consequence of): HHLUCH,  $\rho_HVLL$ /SPhysician/Medical ed by the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Diabetes cete has been sig , page 2 should b No 3 Probably 4 Unknown Schrenah in 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 ☐ Yes 2 Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28 R/Outpatient 3 DOA Certification: To 27. Manner of Peath
1 Natural
2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funerel C completely filled Hospite Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 20, 2006 M. Checkley MD BC 99/6795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Check 44 900 S. Caten Avenue 13alhmore, meghan 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 5 2006 a geran Registrar

		1	For State Registrar	State of Maryland	l / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of He te of D	ealth and Death	Mental Hy	giene Reg. No.	200	6 3	0308
	siciar edica	1	I. Decedent's Name (First, Middle, Last) Hilda D. Holton						2. Date of De Month Septem		20,200°	3. Tin	ne of Death
	mine	4	a. Facility Name (If not institution, give a 4100 Glen Park Ro	ad			Notti	Location of Dea .ngham If Under 24 Hr			Balti	nore	
Fune Direc			5. Social Security Number  215-34-2000  Supplementary Security Number  6. Separation of Security Number 1	7. Age (In yrs. la	st birthday) Yrs.	Month	er 1 Year Days	Hours Mir		ay, Year)	9. Bi	rthplace (St Jountry) VLYLAN	ate or Foreign
e Maryland 8a-f show	a sound of		Oa. State 10b. County Maryland Baltimor		Town or Lo	Nota	ingha	m				10	de City Limits Yes 2 💢 No
ath with the 23a or 2		a l	10e. Street and Number 4100 Glen Park R	Road			ip Code	21236			zen of What C	4.	
1215-0036 within 72 hours after death with the Maryland one. than "natural", or items 23a or 28a-f show		ny ru	11. Marital Status  1 Never Married 21 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1		edent of His ecify Cubar 2 <b>X</b> No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or North Rican, etc.)	D-	14. Race - Am Black, Wh Specify:		ın,
Battimore, Maryland 21215-0036  sernit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  mortcant: If the 27 is marked other than "natural", or terms 23a or 28a-f show	ne Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0·12) 12	completed) College (1-4or 5+)	life. I	kind of V DO NOT	rork done d use retired)	u <i>ring</i> most of w	orking Strator		nd of Busines: Lical	s/Industry	
faryland 2 2 should be filed and Mental Hygic Is marked other	inc event,	o pe c	17. Father's Name (First, Middle, Last)  Robert Kellun	1				18. Mother's Na Elizab	ame (First, Middle eth Ho	, Maiden 19art			
re, Maryla s 1 end 2 should f Health and Men item 27 is marke			19a. Informant's Name/Relationship (Ty Lawrence J. Holtor			-			Rural Route Numb				
Baltimore permit. Pages 1 of Department of He Important: If item	ury or our	1	20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	ace of Dispo metery, crer View C	natory o	other place tory	9/2	Date 23/2006	Balt		Mary	
Balt permit. Departi	SDC6		21. Signature of Funeral Service Licens	"Rineken					himunek Baltimo				
Sylvenia in the control of the contr	cal ner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).	ence of):	adde	r ca	ncea				Onset	and Death
O. Box 6 the death certif	or use as	3	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic Other	pregnancy specify)			2	23d. Date of de Month	elivery Day	Year
ds, P. uires that		ה '	Part II. Other significant conditions con	ntributing to death but not resul	lting in the u	nderlying	cause give	n in Part I.			ise contribute ⊒No 3 ☐ F		e of death?
ital Record ian: The law requir	page z snou	Completed							24a. Wha auto perf 1 🗆 Yes		prior to death?	COMPLETION	ings available to cause of
of V hysic	a direct	0	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2  Accident investigation	lospital: 1 ☐ Inpatient 2 ☐ E  28a. Date of Injury (Month, Day Year)	R/Outpatier 28b. Time of Injury		28c. Injury Work	<sup>nr:</sup> 4 ☐ Nursing	eath (Check only Home 5 Res 28d. Describe	idence (		ecify)	
Division of all or Attending Feliar death.	a in by the	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, str	eet, fact	ory, office		28f. Location City or To	(Street an wn, State	d Number or F )	Rural Route	Number,
Hospita 4 hours Funere	completely filler	edical	29a. Certifier Check only one) Certifying Phy	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, deati on and/or in	h occurre vestigati	d at the tim on, in my op	e, date and plac inion, death occ	ce, and due to the	cause(s) date and	and manner a place, and du	as stated.	use(s)
To the within 2	i i	Ž.	29b. Signature and title of certifier  S - Wall -	Waymis		2	9c. License	2149			e signed (Mor		ear)
`	5		30. Name and address of person who $lpha$ Sally Habib $\imath^{lpha}$	10 120 Siste	r Pier	re Dr	ive#	306, 7	towson,	mD	2120	t	
Re	State gistra	~	31. Date filed (Month, Day, Year)  SFP 2. 5 200	32 Registrar's Signat	иге	replant to	12						

			For State Registrar	State of Maryland		artment of H tificate of L			giene 200 Reg. No.	6 30309
	Physicia /Medic		1. Decedent's Name (First, Middle, La Ernest L. Johns					2. Date of De Month	ber 21 20	
}	Examin Funeral Director		4a. Facility Name (If not institution, gines Hospi  5. Social Security Number  6. 5	tel of Bach,	ast birthday)	4b. City, Town, or Balkin If Under 1 Year Months Days	Location of Dea	s. 8. Date of Bir	4c. County of De n / a th y. Year) 9. E	
	yland Now		Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Mar	Director	Md n/a		Balti	Lmore				1 X Yes 2 □ No
	with th	Dire	10e. Street and Number			10f. Zip Code	015		10g. Citizen of What	Country?
	n 72 hours after death with the Maryland "netural", or fleme 23a or 28a-f show adical Examinat mant be notified at	by Funeral	4231 Towanda Av	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	215 ispanic Origin? ( in, Mexican, Pue	Specify Yes or No rto Rican, etc.)	USA 14. Race - Ar Black, W	nerican Indian, hite, etc.
036	urs aft		1 Never Married 2 Married 3 Widowed 4 Divorced	1 MAYes 2 □ No If Yes, Give Year or Dates: WW I	II .	1 □ Yes 2 🕦 No	Specify:		Specify:	Black
21215-0036	within 72 ho ene. then "naturi ne Madical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wi	orking	16b. Kind of Busines	ss/industry
121	77 75 15 15 15 15 15 15 15 15 15 15 15 15 15		17. Father's Name (First, Middle, Las	0	Long	gshoreman		ama /First Middle	Shipping Maiden Sumame)	
anc	a la b	To Be	Charles Wilson					Elizabet		
Maryland	should and Men is marks aumatic	ř	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town, State	o, Zip Code)
	s 1 and 2 should Health and Mer Item 27 is marks other traumatic		Mrs. Carolyn Redm	ond / Daughter	6825 V	Vestridge	Rd. Ba			
Baltimore,	80-		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 🔼 Other (Speci	Tuguidasi ildili Sisis	idon Pa	sition (Name of matory or other place ark Cemet	ery  9/3	Date 30/06	Baltimore	
Balt	permit. Pag Department Importent; I eny Injury o		21. Signature of Funeral Service Lice	Cartras	h 3		ens Ave	. Baltimo	ore, Maryla	and 21229
	Physician		23a. Part1. Enter the disease, or construction of the control of t	polications that caused the deal one cause on each line.	tuhi	er the mode of dyin	g, such as cardi	una HS	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):		0			
	outed and and and and and and and and and an	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence.	uence of):					
68760,	ificate be executed g physicien and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequent	uence of):					
P.O. Box 68	The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3	Ectopic pregnancy	1		23d. Date of o	delivery Day Year
	quires that in signed b uld be deta	Ď	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 □Unknown
of Vital Records,		Completed				100000000000000000000000000000000000000		24a. Was auto perfe 1 Yes	psy prior to death	autopsy findings available to completion of cause of ?
Vita	Physician: Trips certificates ral director, p	Be	25. Was case referred to medical examiner?	Hospital		Oth	or	eath (Check only		
	Phys this ral dir	To :	1 2 es 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	f 28c. Injur	y at		idence 6 Other (S how injury occurred	pecify)
Division	after death. Director: After Jin by the funer	Certification:	1 Natural 5 Pending 2 Accident investigativ 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injury - At ho		M 1	k? Yes 2 □ No		(Street and Number or wn, State)	Rural Route Number,
ā	를 를 들		29a. Certifier 1 Certifying F	building, etc. (Specify  hysician: To the best of my kno	wledge, death			ce, and due to the	cause(s) and manner	
	To the Hospital within 24 hours a To the Funeral completely filled	ledical	one)	iminer: On the basis of examina and manner stated.	tion and/or in			curred at the time,		
	T with	Σ	29b. Signature and title of certifier  2001	goli, us		29c. Licens			September	onth, Day, Year)
Ot	6		30. Name and address of person who Avoev 6. Person who are sided (Month, Day, Year)  SEP 2 5	completed cause of death (Item	23a) (Type,	Priot) HERITAL	OF BA	TMURE	-	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  SFP 2 5	32. Figistrar's Signa	iturg	beeter				

DHMH 17 Rev 1/2001

PATIENT KNOWN AS: EMEST Johnson

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** September 19,2006 3:30 P M Charan Kaur /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laure 1 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗓 F Director Nov 27,1921 India 216-61-9342 Usual Residence of Deceden the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itams 23s or 28s-1 show other traumstic event, the Medical Examinar must be conflist at 1 ☐ Yes 2 ▼ No Directo Maryland | Montgomery Burtonsville 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code with 20866 India 4312 Sugar Pine Court death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after □Yes 2X No 1 Never Married 2 XMarned Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Asian-Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 0 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event <u>once</u>. 17. Father's Name (First, Middle, Last) Be Ma1o Kaur Singh La1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4312 Sugar Pine Court Burtonsville, Maryland 20866 Mamanmohan Singh/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2X Cremation 3 Removal from State West Arundel Crematory 9/21/2006 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to re of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Thomas that o uanita ( Odenton, Maryland 21113 1411 Annapolis Road 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Bronchospasm 1 day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed inding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been sig Acute myocardial infarction Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an <u> Hypertensive Heart Disease</u> page 2 s autopsy performed? certificate 2**X** No 1 Yes 2X No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death |Check only one| examiner' Hospital: 1 Xinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rable September 19, 2006 MD D0047707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rita Pabla, MD 13621 Baltimore Avenue Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Signature State SEP 2 5 2006 Registrar

			For State Registrar	State of M	aryland /	Depa Cer	artment rtificate	of H	ealth a	nd M	ental Hyg	piene giene 2 0	06	30311
	Physici	an	1. Decedent's Name (First, Midd								2. Date of Dea Month Septemb	Day 21	2006	3. Time of Death
	/Medic Examin	al	U10 4a. Facility Name (If not institution	Lige on, give street and number)			4b. City, T	fown, or	Location o	f Death	Sep cellin	4c. County o		6:12 p M
	LXaiiiii	CI	Gilchrist				Tow	son				Balt.	imor	e
	Funeral Director		5. Social Security Number 220-36-6574 Usual Residence of Decedent	6. Sex 7. Ag 1 (∑ M 2 ☐ F	ge (In yrs. last i	birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Feb. 11	, 1941	9. Birthp Coun ES	lace (State or Foreign try) tonia
	yland		10a. State 10b. County		10c. City, To								1	Od. tnside City Limits
	he Mai	ector		imore	Balt	imor								1 ☐ Yes 2 🛣 No
	ath with II 23a or 2	rai Dir	10e. Street and Number 292 Stanmore	Road			10f. Zip (	21	.212			I0g. Citizen of WI	us Coun	
980	be filed within 72 hours after death with the Maryland hat Hygiene. ed other then "neturel", or Items 23a or 28e-f ehow event. The Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Mai  3 □ Widowed 4 □ Divorces	If Yes Give	?	1	Was Decede If Yes, speci 1 ☐ Yes 2			gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Race Black Specify:	, White,	
Maryland 21215-0036	within 72 ho ene. then "netu	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4or +4		(Give life.	dent's Usual kind of work DO NOT use nanci	k done d e retired,	<i>furing</i> most )		ng	16b. Kind of Bus		dustry
land 2	uld be filed fental Hygir rked other tlc event.	To Be Co	17. Father's Name (First, Middle, Bernhard Lig	, Last)			nanci		18. Mothe	r's Name	(First, Middle, Singh	Maiden Surname		
Mary	nd 2 shoulth and N 27 is ma		19a. Informant's Name/Relation: Mrs. Jacqueline		1							r, City or Town, S		Code)
Baltimore,	permit. Pages 1 and 2 should b Depertment of Health and Ments Important: If Item 27 is marked any Injury or other traumatic e once.		20a. Method of Disposition  1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ceme	of Dispo	sition (Nam natory or oth )f Fai	e of her place	9)	D	ate	20c. Location - C	ity or To	
Balti	permit. Depertrangements any Injugance.		21. Signature of Funerat Service	Licensee		22 F	Name and	OWS C	n Fur	neral	Home,	Inc 21204		
)	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)	t only one cause on each li	ine.	o not ent Star	er the mode	of dying		cardiac o	respiratory arr			Approximate Interval Between Onset and Death
,092	ate be executed hysicien and the burial-transit	icai Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G	a consequence									
.O. Box 68	death certific e attending p id for use as f	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetat dea		Ectopic pre					23d. Date Mont		ry Day Year
rds, P	signed d be de	þ	Part II. Other significant conditi	ons contributing to death t	out not resulting	g in the u	nderlying ca	iuse give	en in Part I.					e cause of death? ably 4 Unknown
of Vital Records,		Completed									24a. Was a autops perform	sy pri med? de		osy findings available inpletion of cause of
Vita	Physician: 1 this certificer ral director, p	Be	25. Was case referred to medica examiner?	Hospital				Othe			Check only or			$\pi$
ion of	After	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date of triju	ent 2 ER/ ury 28t ay Year)	Outpatien  Time of tnjury		3c. Injury Work	at	2		ence 6 Other ow injury occurred		Hospice
Division	al or Attandi s after death. Il Director: A	Certification:	3 ☐ Suicide 6 ☐ Could	mined 288. Place of the	jury - At home, tc. (Specify)	farm, str	eet, factory,	office		2	8f. Location (Si City or Town	treet and Number n, State)	or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funsral Direct completely filled in by	edical	29a. Certifyi (Check only one)	ng Physician: To the best I Examinar: On the basis of and manner st	of my knowled of examination tated.	dge, deatl and/or in	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	nd due to the cod at the time, d	ause(s) and man ate and place, ar	ner as st nd due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certific	they Rile	, me	)	29c.	License	number 201		2	9d. Date signed Septen	(Month, l	ated. the cause(s)  Dey, Year)  2 ( ) ≥ 0 0 6
/	21		30. Name and address of person  W, A - R	who completed caused of	death (Item 23a	а) (Туре, 701	Print)	Ch	enle,	St.	Balto	o. md	212	04
	Sta Registr	_	31. Date filed (Month, Day, Year SEP 2 5	2006 32 32 33 isti	rar's Signature	S. S.	wi							

DHMH 17 Rev 1/2001

ORIGINAL

	1 - State of Maryland / Dep	partment of Health and Mental ertificate of Death	Hygiene 200	6 30312
Physician	1. Decedent's Name (First, Middle, Last)  Robert Lawson Lowdermilk	2. Date Moni	of Death	
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  TRANKLIN Squake Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death  ROSE date  (1) If Under 1 Year   If Under 24 Hrs.   8, Date	4c. County of Dea	
Director	220-10-2884 1 □XM 2□ F 89 Yrs. Usual Residence of Decedent	Months Days Hours Min. Dec.	of Birth th. Day, Year) 9. Bir 14, 1916 Ma	ryland
the Maryland 28a-1 ahow nutilised at rector	10a. State 10b. County 10c. City, Town or to Maryland Baltimore	Location Perry Hall		10d. Inside City Limits 1 ☐ Yes 2 No
th with the Ma 23a or 28a-1a at Le mutilies	10e. Stroet and Number 4027 Schroeder Avenue	10f. Zip Code 21128	10g. Citizen of What C	ountry?
-0036 2 hours after death values; or items 23 all Examinational ced by Funeral	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 XNo Specify:		
215 215 215 215 215 215 215 215 215 215	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) DWNCA	16b. Kind of Business Service St	
B se a s	17. Father's Name (First, Middle, Last)  Frederick Lowdermilk	18. Mother's Name (First, A Edith	Rogers	
		ling Address (Street and Number or Rural Route 18 8 Mt. Airy Drive, Mt. A		_
Baltimore, North Pages 1 and Department of Health Important: If Item 2 eny injury or other transcent		position (Name of ematory or other place)  ALL Luth Cem. 9/22/200	20c. Location - City of Baltimore,	
Baltim permit. Pa Departmen important: eny injury	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Schimun 9705 Belair Rd., Balti		-
Sycon Cate be executed by Wedical Examiner the burial-transit dical Examiner	Sequentially list conditions of any, leading to immediate cause. Enter Indextyling Due to (or as a consequence of):	iratory arrest	ory arrest,	Approximate Interval Between Onset and Death
Box 6: eath certific attending p for use as clan/Mec		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	olivery Day Year
rds, P. quires that the signed by build be detacted by Physical By	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute t	o the cause of death?
al Record  The law requir cate has been si page 2 should I		24a.	autopsy prior to death?	utopsy findings available completion of cause ol
Division of Vital Records, P.O. Box 6. tal or Attending Physician: The law requires that the death certific is after death.  In alto rector: After this certificate has been signed by the attending ped in by the tuneral director, page 2 should be detached for use as Certification; To Be Completed by Physician/Mec	25. Was case referred to medical examiner?  1   Yes   2   No	of	Residence 6 Other (Specified how injury occurred tion (Street and Number or Roy Town, State)	
Hospi 4 hou Funar Fular Fular	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  1 Medical Examiner: On the basis of examination and/or in and manner stated.	ith occurred at the time, date and place, and due to its ninestigation, in my opinion, death occurred at the	o the cause(s) and manner a time, date and place, and du	s stated. e to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier	29c. License number  D0063974	29d. Date signed (Moni	th, Day, Year)
20	30. Name and address of person who completed cause of death (Item 23a) (Type TR. IMRON 5 ddig; 9000 Flori Kby	Sadk Baltimore	HD 21237	
State Registrar	31. Date filed (Month, Day, Year) SEP 2 5 2006 SEP 2 5 2006	edi		

State of Maryland / Department of Health and Mental Hygiene 2006 30313 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 2006 5125 PM SEPT Virginia Mary Loats /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE ST AGNES HEALTH CARE 8. Date of Birth (Month, Day, Year) Sept. 21,1918 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2004 Yrs. 88 216-16-6924 Sept. Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f ehov jiene. or than "natural", or items 23a or 28a-f ehov The Madical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Meyers Drive 21228 USA Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home al Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be filment of Health and Mental H John Joseph Harrigan Pauline Luebeck P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Loats 5929 Charnwood Road; Catonsville, MD 21228 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once. Owings Mills, Maryland 9-28-2006 Garrison Forest 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final YAG **Physician** CEREBRAL EDEMA resulting in death) /Medical Examiner INTRACEREBIAL HEHORPHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 2X No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, data and plane, and due to the nause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P20656 SEPT 22 2006 30. Name and address of person who couled cause of death (Item 23a) (Type, Print) 10 KONSTANTIN ZUBELEVITSKIY 9005 CATON AVE, BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 5 2006 Registrar

		1 - For State Registrar	State of Maryland	d / Departn <i>Certifi</i>	nent of H	ealth and M Death	lental Hygie		30314
Physic		1. Decedent's Name (First, Middle, Las		iew			2. Date of Death Month	Day Year	3. Time of Death
/Medi Exami Funeral		4a. Facility Name (If not institution, give 8088 Kavanaa 5. Social Security Number	street and number)  R  Age (In yrs. In	4b.	City, Town, or  Dunce Under 1 Year Inths Days	Location of Death  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Deat  Baltin  9. Birt  Co	hplace (State or Foreign untry)
Director	tor	Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Locatio	adal b	<	Dec al	1985	10d. Inside City Limits
with the 3a or 28a	Funeral Director	10e. Street and Number 8008 Kavana	1	10	Of. Zip Code	71999	10g.	Citizen of What Co	untry?
ite; Mall yiallia Z. i.Z. i.D. 0000 s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or iteme 23s or 28s-f show other traumatic event, the Madical Exprimer must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
od within 72 hogiene.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		life. DO N	s Usual Occupa of work done of IOT use retired,	luring most of work )	ing 16t	Dennes	
should be filed with not Mental Hygiene is marked other than unatic event, the same in the	To Be (	17. Father's Name (First, Middle, Last)  Artic Fost  19a. Informant's Name/Relationship (7)		19h Mailing Ac	kiress (Street a	Stani	e (First, Middle, Mail Ski Za al Route Number, Ci	Nou	Jacki
permit. Pages 1 and 2 sho Department of Health and Important: If them 27 is m any injury or other traum pages.		20a. Method of Deposition  1 Burial 2 Defermation 3  4 Donation 5 Other (Specify  21. Signature of Tuneral Service Licen	Removal from State	ace of Disposition emetery, cremator	Bridge (Name of	emon Te	Date 200	Location - City or	TOWN, State
Physician /Medical Examiner		23a. Part1. Enir the disease, or companies took, inheart failure. List only of immediate cause (Final disease or condition resulting in death)	one cause on each line.	estudence of):	e mode of dying	cart Fo	or respiratory arrest,	PA L	Approximate Interval Between Onset and Death
ate be executed hysicien and the burial-transit	licai Examiner	Squentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequ	ience oi):	100x	in			54r
To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2★ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □Ecto	opic pregnancy er (specify)			23d. Date of deli Month	ivery Day Year
v requires thet been signed b should be deta	<u>و</u>	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the underl	ying cause give	en in Part I.	23e. Did tobace		the cause of death?
Physician: The law requir Physician: The law requir this certificete has been si	Completed	unoni rer	ial failur				24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
anding Physician: The lavanth. The lavanth. The this certificate has the funeral director, page 2	ertification; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury Work	or: 4□ Nursing Ho	me 5 Residence 28d. Describe how i		cify)
To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certific	3 Suicide 6 Could not be 4 Homicide determined	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			iral Route Number,		
the Hospi in 24 hou the Funer pletely fill	Medicai	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my know tiner: On the basis of examinat and manner stated.	wledge, death occion and/or investig	gation, in my op	oinion, death occur	red at the time, date	and place, and due	to the cause(s)
or West	2	29b. Signature and title of certifier	Im mo		29c. License			Date signed (Mont) スープンして	
9		30. Name and address of person who o	MeGUIRE	W.D	1				NO ZIZZY
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 5 2006	32. Registrar's Signat	turo!					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006

		For Stete Registrer			tificate of D			, No.		
Physicia	an	<ol> <li>Decedent's Name (First, Middle, Last)</li> <li>John Francis Naure</li> </ol>	ot				2. Date of Death Month Septembe	Day 18	Year 2006	3. Time of Death 3:24am M
/Medic Examin		4a. Facility Name (If not institution, give stre			4b. City, Town, or Lo	ocation of Death	Бересшье		y of Death	
LXAIIIII	e.	2732 Old Liberty			Sykesvi1	.1e		Carro	11	
Funeral Director		-10 10 051E N	2□F 7. Age (In yrs. 87	last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Sept 25	1918	9. Birth Cou Md	place (State or Foreigi ntry)
yand wom		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo		<del></del>				10d. Inside City Limits
e Man	Md Carroll Sykesville									1 ☐ Yes 2 🕅 N
th with the 23s or 28 sales for	ai Director	10e. Street and Number 10f. Zip Code 2732 Old Liberty Road 21784					100	g. Citizen of USA	What Cou	ntry?
permit. Pages 1 and 2 should be littled within 7 c hours are result with the maryania Important if them 27 is marked other then "naturel", or flems 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be notified at <u>once.</u>	by Funerai	11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1⊕Yes 2□No 194 IVYes, Give Year or Dates: 194	13-	Was Decedent of Hisp fYes, specify Cuban, 1 ☐ Yes 2√ No	nanic Origin? (Spe Mexican, Puerto Specify:	city Yes or No- Rican, etc.)	Bta	ce Amen ack, White ify: whi	
natur	eted	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a. Deced	dent's Usual Occupation	on ring most of worki	ng 10	5b. Kind of E	Business/Ir	ndustry
then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	mech	kind of work done dur DO NOT use retired) anic			autom	otive	!
Hygie Sthert ant, in		17. Father's Name (First, Middle, Last)		1.	1:	8. Mother's Name	(First, Middle, Ma	aiden Surna	me)	
Aental Aental TKed of tic ev	To Be	John Naurot				Alberta	Feezer			
and Men ie marke	( )	19a. Informant's Name/Relationship (Type,	Print)		ng Address (Street and					
m 27		John Naurot (son)	20h		Old Liber			le, M		
tment of h		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	IOVALIIOIII ŞIALU	e View	sition (Name of matory or other place) Memorial	9-21-	-06 Sy	kesvi	11e,	Md
Departr Departr Importa any Inj		21. Signature of Funeral Service Licensee Page Hught 5	erbert		.O. Box 19					Chapel
Christe be executed by Science and be brighted by Science and as the burial-Itansit as the brighted by Science as the brighted by Science and Brighted by Science and Brighted by Science and Science	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Socialities in tending to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d  d	Due to (or as a consection of the to (or a consection of the to (or a consection of the to (or a	quence of):	vgual	. a 1	ea je			to y co
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	al death 3[	Ectopic pregnancy Other (specify)		permental s		ate of deliving	very Day Year
w requires men been signed by should be deta	ام	Part II. Other significant conditions contri		sulting in the u	aderlying cause given	_	23e. Did toba			the cause of death?
ine ia ate has page 2	Completed	O					24a. Was an autopsy perform	ed?	prior to death?	opsy findings availat ompletion of cause o 2 No
rnysicien: Inel this certificate har ral director, page	Be	25. Was case referred to medical examiner?	pital:	758/0-1	Other		(Check only one		h (C	4.1
rnys arthis eraldi	7.	1 Yes 2 No	28a. Date of Injury	28b. Time o	f 28c. Injury a	at	me 54 Resider 28d. Describe hov			iry)
Attending r death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Ye	s 2 No				
of Attende	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec		reet, factory, office		28f. Location (Stre City or Town,		nber or Rui	ral Route Number,
To the Hospitel or Attending Fra within Z4 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai Ce		ien: To the best of my kn r: On the basis of examin and manner stated.							
To the within ; To the comple	Med	(Check only '2   Medical Examine one)  29b. Signature and title of certifier  30. Name and address of person who com  31. Date filed (Month, Day, Year)  SEP 2 5 2006	100 Tr	w	29c. License	number 771	29	d. Date sign	aed (Month	Pay, Year)
6		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type,	Print) Levsbu	& MY	>>178	y S	teve	no.llet
Sta Regist	ate	31. Date filed (Month, Day, Year) SFP 2 5 2006	32 Registrar's Sign	ature	exe					

		•	1 - State Amend item#20b,p	State of MarylanderFH,G859,9/28/06	d / Depa T <sup>T</sup> Cer	artment of H tificate of L	lealth an D <i>eath</i>	d Mental Hy	giene 200	6 30316
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Ye	3. Time of Death
	/Medic	ai	Joselito C. Ocamp		SEPTEMBER  4b. City, Town, or Location of Death			4c. County of E		
	Examin	er	4a. Facility Name (If not institution, give s Saint Joseph N		er	4b. City, Town, or		/SOTI		ltimore
	Funeral Director		031 30 3133	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Win. (Month, Da Jan. 14	v Year)	Birthplace (State or Foreign Country) hilippines
	land ow II		Usual Residence of Decedent  10a. State 10b. County	10c. City	. Town or Lo	cation				10d. Inside City Limits
	Mary B-fah	tor	Md. Harford		I	Bel Air				1 ☐ Yes 2 ☐ No
	ith the	Director	10e. Street and Number			10f. Zip Code	01/		10g. Citizen of Wha	•
	eath w	erai	506 Hanna Road	12. Was Decedent Ever in U.S	3 13 1		014	? (Specify Yes or No	U.S.A	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28e-f ahow any injury or other treumatic avant, I've Medical Exact arms the routiled at once.	by Funerai	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	fYes, specify Cuba I□Yes 2 ② No	n, Mexican, P	ruerto Rican, etc.)	Black, V	vhite, etc.
2	72 hou	eted	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa	durina most of	workina	16b. Kind of Busine	ess/Industry
21215-0036	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	phys:	DO NOT use retired	()	g	health ca	re
р Д	filed v Hygie other t	O O	17. Father's Name (First, Middle, Last)	) <del>+</del>	pilys.	LCTall	18. Mother's	Name (First, Middle		
<u>a</u>	Aental Aental rked c	To Be	Damian Ocampo				Roque	esa Carmon	na	
Maryland	2 shot and N is ma	. 63	19a. Informant's Name/Relationship (Ty	oe, Print)					er, City or Town, Sta	te, Zip Code)
e,	1 and Health IIM 27		Hilda M. Ocampo/t			Hanna Roa	d, Bel	Air, Md.	21014 20c. Location - City	or Town State
Baltimore,	ages int of h t: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	metery, cren	natory or other plac	9/4	25/2006		
뺥	mit. P partme portan r injur.	1	4 Donation 5 Other (Specify), 21. Signature of Furginal Septine License	mausoleum   H1g	22	Memorial Name and Addres	ss of Facility		Fallston	
<u>m</u>			Ill tille						f Bel Air, L Air, Md.	
		0 79	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death le cause on each line.	. Do not ent	er the mode of dying	g, such as cai	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ADVANCED N		1ALL CEL	L LUN	IG CANCER	₹	
	Examiner			Due to (or as a consequ ACUTE MYEL		EUKEMIA	ì			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):						
72.	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		onno of):	):				
8760,	icate be executed physician and s the burial-transit	aiE	L.	Due to (or as a consequ	erice or).					
687	ifficate g phys as the	edicai								
.O. Box	The law requires that the death certifi ate has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
۵.	uires that signed b	þ	Parti. Other significant conditions continuously to death out not resolving in the uniquelying cause given in Parti.							e to the cause of death?  Probably 4 Munknown
Vital Records,	ie taw requir has been si ge 2 should	Completed						24a. Was		a autopsy findings available to completion of cause of
ž		Com						perfo	rmed? deat	
Vita	Physician: Th r this certificate ral director, paç	Be	25. Was case referred to medical examiner?	lospital:		othe Othe	or	Death (Check only		ave V
ō	Phys ar this aral di	7; To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injun	y at		dence 6 Other (	Specify)
Ö	Attending ir death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	K? Yes 2∐No			
Division	after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location ( City or To		r Rural Route Number,
	To the Hospitei or Attanding Physician: within 24 hours after death.  To the Funeral Director: Attar this certific completely filled in by the funeral director,	edicai C		sician: To the best of my knowner: On the basis of examinat and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	m-ella m		29c. License	e number		29d. Date signed (M	11
		W.	2 Julyou	in i cita m	0	D 41	410	5	etlembn 1	5th, 2006 "
	10	1	30. Name and addr ss of person who co				Allen er	OHEOR!	IAMVI AND	01.007
	Sta	ite	JOGINGER P. MEH 31. Date filad (Month, Day, Year) SEP 2 5 2006	32. Registrar's Signat	ure	SLER DR	I WY	יאטטאי וי	IARYLAND	CICUH
	Registi		SEP 2 5 2006	Siener 15	Speed	5				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ATAN 1174 4 peritt 361, 11/3/06 WS
State of Maryland / Department of Health and Mental Hygiene 2006 30317 Certificate of Death Reg. No. 2. Date of Death Month I. Decedent's Name (First, Middle, Last) 3. Time of Death Year 12:58 AM September 20 William 2006 John Price 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 3, 9. Birthplace (State or Foreign Country) California 5. Social Security Number 7. Age (In yrs. last birthday) Days Year) 1915 Months 1X M 2□ F 553-16-3807 90 Yrs. Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3710 Kimble Road 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1936

If Yes, Give Was Decedenl of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Florence Hodge John William Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Frances Price (Wife) 3710 Kimble Rd., Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/23/06 Cyrus Veney Family Luray, VA 4 □ Dogration 5 □ Other (Specify) <sup>22, Name and Address of Facility</sup> The Bradley Funeral Home, Inc. 187 E. Main St., Luray, VA 22835 21. Signa are of Juneral Service Licensee meen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Aspiration Preumonia Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of):

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland Hyglene.

Baltimore, Maryland 21215-0036

John Price

Known

to

or then "natural, or iteme 23s or 28s-f show to Medical Examiner must be notified at

or other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any njury or other treumatic event once.

> ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit filled in by the funeral director.

the Hospital or Attending Physician: The law requires that the death certificate be executed

After this

within 24 hours e To the Funerel

2

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant al time of dea 9 □ Unknown	death 3 Ectopic			23d. Date of delivery Month Day Year		
Part II. Other significant conditions co	-	ting in the underlying	g cause given in Part I.		se contribute to the cause of death		
Diabetes 1 Parkinson's	Mellitus			1 🗆 Yes 2 [	□ No 3 □ Probably 4 🕦 Unkn		
Parkinson	Discase			24a. Was an autopsy performed? 1 ☐ Yes 2 🔀 No	24b. Were autopsy findings avail prior to completion of cause death? 1 ☐ Yes 2 ☐ No		
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			
1 ☐ Yes 2⊠ No	Hospital: 1 ☐ Inpatient 2 🗷 E	R/Outpatient 3	DOA Other: 4 Nursing H	Home 5 ☐ Residence	5 □Other (Specify)		
27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	et and Number or Rural Route Number, State)		

Diabetes	1 □ Yes 2 [	No 3 Probably 4 ⊠Unknown					
Parkinson	S Discase				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
25. Was case referred to medical			- 200	26. Place of De	eath (Check only one)		
examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing	Home 5 ☐ Residence 6	G ☐Other (Specify)	
27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1  Yes 2 No	28d. Describe how injury	y occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined				ffice	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	ysician: To the best of my kn iner: On the basis of examin and manner stated.					and manner as stated. place, and due to the cause(s)	

State Registrar

Medicai

29b. Signature and title of certifier

2401 W Belvedere Hansen Chad 31. Date filed (Month, Day, Year)

29c. License number

D59062

30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)

Baltomore MD 21215

29d, Date signed (Month, Day, Year)

September 20, 2006

SEP 2 5 2006

Christopher Martin Purdy

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

2006 30318

1. For State Certificate of Death Rea No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day Year September 16, 2006 Purdy 1402 hrs Medical Examiner Christopher Martin 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Harford 514 Shore Drive Joppa 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) Funeral Foreign Director 217-98-2690 CountryMaryLand 12/10/1965 1 X M 2 40 Usual Residence of Deceden 10b County 10c. City. Town or Location 10d Inside City Limits any or 28a-f show s 23a or 28a-f show e notified at once. 1 Yes 2 X No Maruland Harkord Joppa with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21085 U.S.A. 514 Shore Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 X Yes If Yes, Give Year or Dates: Widowed 4 Divorced 1 Yes 2 X No specify White 3 Specify þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Pages 1 and 2 should be filed within 72 ho nent of Heath and Mental Hygiene ant. If item 27 is marked other than "na or other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Project Manager Electrical Company 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Katzenburaer Be George Purdu 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 (wife) 514 Shore Drive, Joppa, MD 21085 Shirley J. Purdy 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Important: I 9/21/2006 Baltimore, Maryland Parkwood Cemetery Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 an 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - tran sician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g860, 10/6/06 TT Box 68760, IF FEMALE: 23d Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed Division of Vital Records, 24b Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death 25 Was case referred to medical 26. Place of Death (Check only one) Be Other<sub>4</sub> examiner? Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 this 1 🗸 Yes ဥ 27 Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c Injury at Work? 28d Describe how injury occurred Certification: Natural Yes 2 X No 5 Pending within 24 hours after death Fo the Funeral Director: Fnd 9/16/2006 | Fnd 1:58 pm Unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 514 Shore Drive 28e Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide determined (Specify) House 1 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2H O.C.M.E September 17, 2006 Morrie pind 30. Name and audress of person who completed cause of death (Item 23a) Assistant Medical Examiner Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature SEP 2 5 State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

Month

Day

SEP 16 2006

Year

MONTGOMERY

14. Race - American Indian,

Black, White, etc.

Specify: White

Canada

4c. County of Death

5:55 A

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

18/2006.

BETHESDA MD 20889-5600

CENTER

Year

1 Yes 2 No

9. Birthplace (State or Foreign

WINNIFRED DIXON REDD

State Registrar DHMH 17 Rev 1/2001 1 - For State Registrar

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

CAPT

MC

USAF

ANDREW J. PETERSON

SEP 2 5 2006

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 2006 30320 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 18, 2006 **Physician** 9:39 p M Harold Bruce Richardson, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Bel Air 509 Applewood Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | Oct. 30, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Mary Land 79 Yrs Director 219-10-4400 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits raf', or frems 23a or 28a-f show Expulsion count by notified at Harford Bel Air 1 ☐ Yes 2 ☐ No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21014 509 Applewood Drive filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 20 Marned Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
supervisor outside
service foreman 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (C&P Telephone) Elementary/Secondary (0-12) Colfege (1-4or 5+) communications 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Heart: if item 27 is marked oth Mildred Kelly William A. Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 509 Applewood Drive, Bel Air, Md. 21014 Grace Richardson/wife permit. Pages 1 and Department of Healti important: if itam 27 any injury or other tonce. othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/22/2006 Highview Mem. Gdns. Fallston, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) arold **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes funeral director, 25. Was case reterred to medical examiner? Be 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 2 5 Aesidence 6 □Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a

To the Funarai I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) 127730 30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print) Of N. CHAMES ST. BATIMONE, AV COVIEN 65-69 40 32. Hogistrar's Signature 31. Date filed (Month, Day, Year) State SHELLEN . Registrar

		1 - For State Registrar	State of Marylan	nd / Depa <i>Cer</i>	artment of rtificate o	f Health and I of Death	Mental Hy	giene 2 (	106	3032
Physic	ian	1. Decedent's Name (First, Middle, Last)	ELTON		CLIFFE		2. Date of De Month	ath Day	Year	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give s		1 021		n, or Location of Deatl	SEPT	4c. County	of Death	
			Hospital			Bethesda			lontgo	
Funeral		5. Social Security Number 6. Sex	M 2DF	last birthday) Yrs.	If Under 1 Ye Months Day	ar If Under 24 Hrs. ys Hours Min.	(Month, Da			ace (State or Foreign ry)
Director		214-42-4214 Usual Residence of Decedent	63				December	6, 1942	I	ndiana
uylanı show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10	d. Inside City Limits
Ba-fa	Director	Maryland Montgo	mery		<del></del>	Bethesda				1 Tes 2 X No
with ti		10e. Street and Number	D 1 1		10f. Zip Cod		10g. Citizen of What			•
death ms 23	Funeral	5731 Bradle	12. Was Decedent Ever in U	I.S. 13. V	Was Decedent of	20814 of Hispanic Origin? (S	pecify Yes or No	- 14. Race	e - America	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show only injury or other traumatic event, the Madical Exeminar must be notified at energy injury or other traumatic.	by Fur	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		fYes, specify C 1 □ Yes 2🛣 N	uban', Mexican', Puèrt No <i>Specify</i> :	o Rican, etc.)	Specify	k, White, e	white
21215-0036 bd within 72 hours all giene. ar than 'natural', or ar than 'matural', or in Madical Exemi	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occ	cupation		16b. Kind of Bu		
215 Bithin 7 Ben 'n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use ret	ne during most of wor ired)	King	De	partm	nent
121 Bed will Mygien At. In		47 Fabrus None (Final Middle ( and)	5+	D	istrict	Superviso		of Juve	nile	Services
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	Be	17. Father's Name (First, Middle, Last)	T1. D . 1.	<i>c.c.</i>			ne (First, Middle,			
should not he mark	7	19a. Informant's Name/Relationship (Ty	Elton Ratcli		ng Address (Stre	eet and Number or Ru	Martha  Iral Route Number			
Mand 2		Michele R. Ratcl	iffe/ Wife	573	1 Brad1	ey Bouleva	rd Beth	esda. Ma	rvlan	nd 20814
Baltimore, permit. Pages 1 ar Department of Heal mportant: If item my injury or othe my injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R		Place of Dispo	sition (Name of	nlace)	Date	20c. Location -		
timent tant:   Jury o		4 ☐ Donation 5 ☐ Other (Specify)	c	remato	gomery rium In	c. Sep	tember , 2006	Betheso	la, Ma	aryland
Balt permit Depart import eny in		21. Signature of Funeral Service License	~ /,	335 Be	Name and Ade thesda- thesda.	dress of FacilityRob Chevy Chas Maryland	ert A. se, Inc. 20814-3	Pumphrey 7557 Wi 501	Fune scons	ral Home/ sin Avenue
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ations that caused the deat						1	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CHOIS JGIE	Contan	200				1	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq							
90		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
ansit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
8766, cate be executed physicien and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):								
878	dical	d							-	
Box 6  Beath certific attending F	/We	IF FEMALE:	3c. If yes, outcome of pregna	ancy				22d Day	a of dollars -	
BOX death cerr	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl déath 3 □	Ectopic pregnal Other (specify)			Mor	e of deliver oth D	y Day Year
P.O. that the deby the detached	hys	9 Unknown	9□ Unknown							
. v 8 68	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause	given in Part I.	23e. Did to	obacco use contr res 2 la No		cause of death?
13 > 0 5	etec						24a. Was			
I Rec	Completed						autop perfo	osy p rmed? d	rior to com	sy findings available pletion of cause of
Vital F Vital F sicien: Th certificate	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o		☐ Yes 2	2∐ No
G : S	To B	examiner? 1 ☐ Yes 2 No	ospital: 1) Anpatient 2 🗆	ER/Outpatien	t 3 DOA	Othor	ome 5□ Resid		or (Specify)	
T C B P P	ë.	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	V		28d. Describe h	now injury occurre	ed	
Division  or Attending after death.  Director: After din by the fune.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	Ome farm str		☐ Yes 2 ☐ No	28f Location /	Street and Number	ar or Pural	Pouto Alumbos
DIVISITIES OF ARTER O	Certification;	4 Homicide determined	building, etc. (Specif	(y)	eer, ractory, onic	Se .	City or Tow	vn. State)	or Hurari	noule Number,
Divisio  Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exemination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and place y opinion, death occu	, and due to the cred at the time,	cause(s) and mar date and place, a	nner as sta and due to t	ted. he cause(s)
To th within To th	Me	29b. Signature and title of certifier				ense number		29d. Date signed	(Month, D	ay, Year)
		1 thm 4pc	>		D	19675		Sur Z	· 200	6
10	9	30. Name and address of person who co	mpleted cause of death (Item			2		SUA, r	7	
,		31. Date filed (Month, Day, Year)	(CIA MD	67/20	Rockel	£06€ 4	BETHO	SDA, r	VID	
St Regist	ate trar	SEP 2 5 2006	/32. Registrar's Singa	1000				/		

06-07046 Stephanie Riley

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 30322

		1- For State Registrar	Cermicale of Deam				6 3032
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last)  Stewanie, Rile	V		2. Date of Death Month September	Day Year	3. Time of Death 0850 hrs
		4a. Facility Name (if not institution, give street and number) 4916 Aberdeen Avenue	4b. City, Town	, or Location of Death		4c. County of Death	Δ
Funeral			In yrs. last birthday) If Under 1	Year If Under 24Hrs	_	(MM/DD/YYYY) 9. Bin	
Director		1_M 2_F	50 Yrs Months	Days Hours Min	July 1	9,1956 Foreign	untry) New Jersey
/ any	l	Usual Residence of Decedent  10a State 10b County 10	Oc. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	ţoţ	Mayland NITT  10e, Street and Number	10f, Zip Coo	timore	140	g. Citizen of What Cour	1 Yes 2 No
ith the Maryland 23a or 28a-f sho	Oire	4916 Aberdeen Ave.	2	1206		g. Chizen of What Cour	Ä
or items	Funeral		No If Yes, specify Cu	f Hispanic Origin? (Spuban, Mexican, Puerto		White, etc.	ican Indian, Black,
hours after "natural", Examiner	ğ	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete.	eted) 16a Decedent's Usual Occi	upation (Give kind of		Specify: Wh	
	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working		ired)	NA	
21215-0036 uld be filed within 7 Mental Hygtene marked other than c event, the Medical	e Con	17. Father's Name (First, Middle, Last) William Hamer		18.Mother's Name	e (First, Middle, M.	aiden Surname)	
Z 2 6 2 2	മ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (S	treet and Number or	Rural Route Numb	per, City or Town, State	, Zip Code)
and 2 sho lealth and tem 27 is traumati		Sharron Kiley-daughter 20a Method of Disposition	2674 Wilk 20b. Place of Disposition (Name of		. Batti	nore, Mary	land 21023
imore, MD 2 Pages 1 and 2 shou ment of Health and N iant: If item 27 is n or other traumatic		1 Burial 2 Cremation 3 Removal from State	crematory or other place)	a cemetery,	125/0/2	Catonsville	Mandad
Baltimore, permit Pages I at Department of He Important: If ite	ł	4 Donation 5 Other Specify: 21. Signature of Fur Livil Service Lipensee	Metro Cremator	ress of Facility Par	Ker Fun	eral Home,	
ய உத்தத் Physician	-	23a Part I. Enter the disease, or complications that caused the	e death. Do not enter the mode of dy	denck Aving, such as cardiac	e Ball	more, Mar	YIAN Approximate Interval
/Medical Examiner	ı	failure. List only one cause on each line  Immediate Cause (Final disease a Methadone	intoxication				Between Onset and Death
-Adminio.		or condition resulting in death)  Due to (or as a consequence of the conditions)	uence of);				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	uence of):				
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of the con	uence of):		_		
760, icate be executed physician and the burial - transit	edical	X UNPENDED amended	#23a,PII,27,28a-f,per	ME. 0859.9/27	7/06 TT		
	3	IF FEMALE: 23b. Was decedent pregnant in the				23d. Date of delivery	/ Day Year
that the death certif red by the attending detached for use as	Physiciar	past 12 months?  4 Pregnant at tin  1 Yes 2 No 9 ✓ Unknown 9 Unknown			,		
O. B. at the de 1 by the tached f		Part II. Other significant conditions contributing to death b	out not resulting in the underlying cau	se given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
S, P.O. uires that th n signed by	ed by	Tuberculosis; Hepatitis C			-	2 No 3 Prob	
Division of Vital Records, tal or Attending Physician: The law requing after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed				24a. Was at autops perforn	y prior to oned? death?	stopsy findings available completion of cause of
ital Rec ician: The l s certificate l		25. Was case referred to medical	26.P	lace of Death (Check	1 Yes 2	No 1 Y	es 2 No
of Vita ing Physicia After this ce uneral direct	To Be	examiner?  1 ✓ Yes 2 No Hospital. 1 Inpatient				Residence 6 🗸 Other	r: Scene
ion of tending Pheath		27. Manner of Death  1 Natural 5 Pending	r)   1[	Injury at Work? Yes 2 V No		ow injury occurred	
Visic or Atte fter dea Director in by th	Certification:	2 Accident Investigation 28e Place of Injur	ry - At home, farm, street, factory, offi	Λ.	28f. Location (St		ral Route Number, City Leen Ave.
Ospital ospital hours a uneral I		4 Homicide determined (Specify) House					
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.					
Val	ğ	29b. Signature and title of certifier		ense number		29d Date signed (Mo	
TXX		30. Name and address of person who completed cause of dea		. O.IVI. E.		September 19, 2	
())~		Ana Rubio MD. Assistant Medical Examir	ner 111 Penn Street, Balt	imore, MD 2120	1		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's SEP 2 5 2006	9 gnature				

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

SEP 2 5 2006

Medical

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Franklin 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D006

29d. Date signed (Month, Day, Year)

06-07173 Cynthia Jo Sammons Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		tificate of I	Death		Re	eg. No. 201	16 3032
Phy edical Ex	sicia (amii		Decedent's Name (First, Middle,Last Cynthia	Jo Sar	nmons	-		2. Date of Deat Month Septembe	Day Year r 23, 2006	3. Time of Death 0818 hrs
			4a. Facility Name (if not institution, giv Kresson Street at Pulaski	Highway		Baltimore	Location of Deat		4c. County of Deat	
Fund Direct			5. Social Security Number 6. S 217 84 7797 1		ast birthday) 46 Yrs.	Months Day		n	3,1960 Co	
	ow any		Usual Residence of Decedent  10a. State 10b. County  Manual and Deliberation		Town or Location	n		-		10d Inside City Limits 1 Yes 2 No
ıryland	a-f sh	cto	Maryland Baltimo  10e. Street and Number	re Bal	timore	10f. Zip Code		10	Og Citizen of What Cou	21
h the Ma	23a or 28a-f show any notified at once.	I Director	4414 Ridge Road				21236		USA	
eath wit	items 2 ust be n	uneral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?  1 Yes 2 X No	S. 13. Was	Decedent of His s, specify Cubar	spanic Origin? ( S n, Mexican, Puert	Specify Yes or No- o Rican, etc.)	- 14. Race - Amer White, etc.	ican Indian, Black,
after d	al", or	by Fi		If Yes, Give Year		res 2 X No			Specify Whi	Control of the contro
2 hours	"natur	ted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	nly highest grade completed)  College (1-4 or 5+)			tion (Give kind of DO NOT use re		16b. Kind of Business/	Industry
5-0036 iled within 7. Hygiene	other than "natural", the Medical Examiner	Completed	9		Care	Giver				Hospice
215-( oe filed v ntal Hygi	ked oth	Be Co	17. Father's Name (First, Middle, Last William Jose	•			18.Mother's Nam	he (First, Middle, N ${ m lyn}$ B:	Maiden Surname) riggs	
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene	it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	اع	19a Informant's Name/Relationship ( Marcelyn Smith (m						nber, City or Town, State aryland 212	
Ore, les I and of Heal	If iten	M	20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from State	Place of Dispositi	r place)		Date	20c. Location - City or	
I <b>ltim</b> nit Pag artment	ortant: ry or o		Donation 5 Other Specify 2 Signature of Tune al Service and		yview Cr 22. Na	enatory me and Addres			Baltimore	
Dep Dep	Import injury		Han 13 a		140	7 Old E	astern A	Avenue Es	ssex Maryla	
Physic /Med	_		2 a First Enter the disease or com finiture. List only one cause on e	ach Inc.	Do not enter the	mode of dying	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Exami	iner		Im diate Cause (Final disease a or condition resulting in death)	Multiple Injuries  Due to (or as a consequence or	f):					
		ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence o	f):					-
V6		Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):					
vecuted	and - transit		d	AMENDED						
<b>760,</b> icate be e	physician and the burial - tra	Medical	UNPENDED  IF FEMALE:	AMENDED  23c. If yes, outcome of pregi	nancy				23d Date of deliver	v
687 certifica			23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	2 Feta		Ectopic pregr	nancy		Day Year
Box 68	the atte	Physicia	1 Yes 2 No 9 V Unknow	n 9 Unknown	J Othe	er (Specify)				
P.O.	signed by the attending be detached for use as	by	Part II. Other significant conditions	contributing to death but not re	esulting in the un	derlying cause	given in Part I.		bacco use contribute to	
Division of Vital Records, tal or Attending Physician: The law require is after death	been si	Completed			,		-	24a. Was a autop		utopsy findings available completion of cause of
<b>Reco</b> The law	cate has	dmo							med? death?	
ician:	s certifi rector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient		Other Nurs		Residence 6 🗸 Othe	r. Coope
of V	ofter thi	7: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Inj		iry at Work?	28d. Describe h	now injury occurred	
Sion offeath	ctor: A	atio	1 Natural 5 Pending 2 ✓ Accident Investigar		0757 hrs		Yes 2 V No		to in collision with	
Divisital or A	neral Director: After this certificate has been filled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could no determine		ome, farm, street	, factory, office I	building, etc.	or Town, S	Street and Number or Ri tate) at Pulaski Highwa	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Fune completely fi	Medical C	29a Certifier 1 Certifying Physic	cian: To the best of my knowleder:On the basis of examination a						
T <sub>o</sub>	T <sub>O</sub>	Me	29b Signature and title of certifier	and manner stated.	<del></del>	29c. Licens			29d. Date signed (Mo	
	n		tatu Uron	ia-Pollet	~~	O.C.	M.E.		September 23, 2	2006
	3		30. Name and address of person who Patricia Aronica-Pollak M			111 Penn S	treet, Baltimo	ore, MD 2120	1	
		tate trar		32 Registrar's Signatu	ire Assets	B				

			For State Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of H <i>tificate of L</i>	lealth and I Death	Mental Hy	giene 200	6 30325
	Dhustal	è	1. Decedent's Name (First, Middle, Las	st)				2. Date of De	eath Day Yea	3. Time of Death
	Physici /Medic		Shirley Faye	Stephen					ber 16, 200	06 4:00 A <sup>M</sup>
10	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Deatl	n	4c. County of De	eath
	· v		Lorien Mt Airy	7 4 //-	and the set to the set of the	Mt. Air	y If Under 24 Hrs.	I o Data at Bi	Carroll	2.4.1
	Funeral		5. Social Security Number 6. S	□M 2ME	vrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Sep. 27	7th 19, Year) 1 1021	Birthplace (State or Foreign Country)
	Director		309-18-2345 Usual Residence of Decedent	84				Sep. 27	,1921 Pu	tnam, IN
	yland tow		10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits
	Mar Mar	ţo	Indiana Cass	Lo	gansport	:				1 ∑Yes 2 □ No
	in the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show he Madical Examinar must be neilliad at		406 Tanguy Street			46947			U.S.A.	
	ems ems	Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	)- 14. Race - Ar Black, W	merican Indian, hite etc
98	or it	γFι	1 Never Married 2 Married	1 □Yes 2 No If Yes, Give		1□Yes 2█ No	Specify:	,	Consider	
Ö	ural',	d by	3  Widowed 4 Divorced	Year or Dates:	10. 5					White
7	n 72 "nat	Completed	15. Decedent's Ec (Specify only highest gra		(Give	lent's Usual Occupa kind of work done o DO NOT use retired	during most of wor	rking	16b. Kind of Busines	ss/Industry
12	withi ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen	_	,		Own Home	2
Maryland 21215-0036	filed Hygi other		17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	, Maiden Sumame)	
an	ld be ental ked (	To Be	L. Herbert Fitzsi	mmons			Lela Ma	e Sander	rs	
ar <sub>y</sub>	shound M	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ıral Route Numb	er, City or Town, State	a, Zip Code)
Ž	nd 2 alth a 27 is		Francis Leo Steph	nen (Husband)	713 N	idway Av	e., Mt.	Airy, MI	21771	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene.  Department of Health and Menth Hygiene.  Department of Health and Menth Hygiene.  Department of Health and Menth Hygiene.  Department of Hygiene.  Department of Hygiene.  Department of Hygiene.  Department Hygiene.  Depar		20a. Method of Disposition	20	b. Place of Dispo			Date	20c. Location - City	or Town, State
Ë	Page nent control nt: if iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State (y)	-	k Cemete		3-06	Logansport	t, IN
a	mit. partin porta porta / inju		21. Signature of Funeral Service Licen	1	22	. Name and Addres	ss of Facility			
m	Depa impo any ir		Dennis (	Tilmen	n 10	undrum Fu 503 E Bro	neral Ho adway, L	me oganspo:	rt, IN 469	47
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		PRK	inson's	101 SRB	CR.		Onset and Death
75	/Medical		resulting in death)	Due to (or as a con			212	0		1000
	Examiner		Sequentially list conditions,	b						
	D ##	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequanea or,.					1
	cate be executed physicien and the burial-transit	cam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con						
8760,	be ex cien ourial	Ë		Due to (or as a con	saquanca or,.					
	physis the	dicai		_ d						
9 X	death certifica attending ph d for use as t	Physician/Me	IF FEMALE:	23c. If yes, outcome of pre	gnancy				22d Data of a	tolivon
Вох	that the death cer ed by the attendir detached for use	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	Fetal death 3□	Ectopic pregnancy Other (specify)			23d. Date of o	Day Year
P. O.	the d y the ched	iysi	1 ☐ Yes 2 ♠ No 9 ☐ Unknown	9□ Unknown	0.000					
	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ds,	uries ald be	d by	Congest	we Heavy	Fzilm	2		10	Yes 2ऄNo 3□	Probably 4 Unknown
Ö	w requir been s should	Completed	)	,				24a. Was	an 24b. Were	autopsy findings available
Be	The lay ate has page 2	mc						auto perfo 1 ☐ Yes	psy prior t	o completion of cause of
ta	icien: Th certificate rector, pag	ပိ	25. Was case referred to medical				26. Place of Dea			es 2 No
Division of Vital Record	ysicien: nis certifica director, p	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	2 DER/Outpatien	t 3 DOA Othe			dence 6 ☐Other (S)	necify)
0	g Ph er thi		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of				how injury occurred	30011)
<u>0</u>	ttendin death. ctor: Aft / the fun	atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation		r) Injury		Yes 2 No			
vis	I or Attending Phater death. Director: After th	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str	eet, factory, office		28t. Location ( City or To	Street and Number or	Rural Route Number.
Ö	tel or A	Certification:		5 diam's, 5 dia (5)				0.1, 0.1.0	, 6.2.6)	
	To the Hospitel or Attending Physicien: within 24 hours after dear Attenting Sentifics To the Funerel Directors After this certifics completely filled in by the funeral director, is	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exam	knowledge, death	occurred at the time	ne, date and place	, and due to the	cause(s) and manner	as stated.
	To the H within 24 To the F complete	edi	one)	and manner stated.	THE ROTE OF THE			mod at the time,	oate and place, and o	de to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	M ( Bel 1	~~	29c. License			29d. Date signed (Mo	
	A		,				59943		Schlamo	1812000
1.	0		30. Name and address of person who	completed cause of death (	(Item 23a) (Type,		7		- m - 7	1150
Y			31. Date filed (Month, Day, Year)	28 Pagintrada S	ionatura	July 30	1 250	MINDER	110	3/
	Sta Registr	-	SEP 2 5 200	až. Registrar's S	1. Aco	el s				

State of Maryland / Department of Health and Mental Hygiene 20061 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sept **Physician** 1808 loan 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, )
Dec. 10, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 67 Yrs. **Funeral** Months Days Hours 1 ☐ M 2 🗙 F 213-36-8588 Maryland Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Perry Hall Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21128 U.S.A. 15 Bangert Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Deperment of Health and Mental Hy important: if Item 27 is marked oth eny linjury or other traumatic event ADEs. Be Edna Seeger Edgar Soistman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Bangert Avenue, Perry Hall, MD 21128 John Shugart (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9/22/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Ta 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final adenocarcinoma 1/26/06--una **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed attending physiclen and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has certificete 1 Yes 2 (X) After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 200 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No deeth. investigation neral Director: A filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direct o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 1 (Check only one) 29b. Signature and title of certifier 29c. License numbe 10-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

2 5 2006

	1 - For State Registrar		State of Ma	aryland	l / Depa <i>Cei</i>	artmer rtificat	nt of H	lealth a D <i>eath</i>	and M		giene 2 Reg. No.	006	30327
Physician /Medica Examine	Willi	e (First, Middle, Last,  G. M.  If not institution, give	taples			4b. City	Town or	Location o	of Death	2. Date of De Month Lep tem	ber 22	200	
Funeral	Baltmore 5. Social Security N	Rehabilite	ation Exter	n eled ( e (In yrs. la			Balt r 1 Year	imore	9	8. Date of Bir (Month, Da	th	NA 9. Birtl	nolace (State or Foreign
Director	228-22-3. Usual Residence of	303	]M 2□F	80	Yrs.		Days	Hours	Min.	7-8-			Va.
the Maryla 28a-f shor	Md.  10e. Street and Nu	Bal	timore	Toc. City,		ALLS.	447 10				10. 0"		10d. Inside City Limits 1 X Yes 2 □ No
23a or		reen Ash C	t.			101. 21		21133			10g. Citizen	USA	untry ?
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other then "naturel; or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	3 ₩ Widowed	ied 2□ Married	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 \( \text{Yes} \)	cify Cuba	ispanic Origin, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	6	Race - Ame Black, White ecify:	
Maryland 21215-0036 d 2 should be filed within 72 hours alt th and Mental Hygiene. 7 is marked other then "naturel; or traumatic event, the Medical Exercit TOPO CONSTRUCT	(Spec				life. I	kind of wo DO NOT u	ork done d se retired	during most	of workir	ng	16b. Kind o	f Business/l	ndustry
ind 2.		GE (First, Middle, Last)				isabl	Lea	18. Mothe	r's Name	(First, Middle,	NA Maiden Sun	name)	
should be and Mental a	Asa	(D. 1.1.)		Stap					Nanni			hompso	
Baltimore, Mary permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is m eny injury or other traum	Lavone  20a. Method of Dis		Daughte	20b. Pla		Gree sition (Nar natory or o	en As	sh Ct.	, Ra	ndallstate	ton, Me	d. 2]	1133
Baltir permit P Departme Importan eny Injury		yeral Service Licenso	90	Gar	22	. Name ar	nd Addres	s of Facility , Md.	y Ma	arch F. 202			101 E. Nort
Cale be executed by sician and by sician and by sician and cale be executed by sician and cale of the burial-transit cale of the	shock, or heal Immediate Cause (Disease or condition resulting in death)  Sequentially list confirmed in the cause, Enter Unide Cause (Disease or that initiated events resulting in death) if	nditions, and the state of the	Due to (or as:  Due to (or as:  Due to (or as:	a conseque	nce of):								Interval Between Onset and Death
the death certification of the attending ached for use as	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal de	eath 3	Ectopic pr Other (sp						Date of delik	very Day Year
law requires that as been signed be 2 should be detained by Dr.	Part II. Other signii	icant conditions con	tributing to death bu	ut not resulti	ing in the ur	derlying c	ause give	in in Part I.			obacco use co ′es 2 □ No		the cause of death? bably 4 Dunknown
- (G LL )										24a. Was autop perfor 1 Yes	SV /	b. Were aut prior to codeath?	opsy findings available ompletion of cause of
of VItal hysician: T hysician: T hysician: T hysician To Ba C	examiner?	/	ospital:	nt 2 🗆 EF	VOutpatient	3 DC	Othe	_		Check only one 5 ☐ Resid		Other (Spec	(fv)
DIVISION OF  or Attending Phy after death.  Director: After this  in by the funeral d  artification: To		5 Pending investigation	28a. Date of Injur (Month, Day	y Year) 21	8b. Time of Injury	M 2	8c. Injury Work 1 □ Y	at	2	8d. Describe h			,,
E S E S		6 Could not be determined	28e. Place of Injubuilding, etc							City or Tow	m, State)		al Route Number,
he Hosp in 24 hou he Fune pletely fil	29a. Certifier (Check only one)	1 Certifying Phys 2 Medical Examin	ician: To the heat of ner: On the basis of and manner sta	examination	n and/or inv	estigation,	at the this in my op	e, date and inion, deat	h occurre	nd due to the t d at the time, o	date and plac	e, and due i	stated. to the cause(s)
To th within To th compl	20h Signature and	title of certifier	Wie	h v	V 11	290	D4	number (365	2	5	29d. Date sig	ned (Month,	Day, Year) 22, 2006
3+1	30 Name and address	ess of person who co	mpleted cause of de	M, D,	3a) (Type, F	Bib L	och	Rav	en B	oulevo	rd Bo	ettim	22, 2006 Ne, MD, 21218
State Registrar		th, Day, Year) FP 2 5 2006	32. Registra	r's Signatur	Amer	ada A							

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Maryla	nd / D (	epartment of H Certificate of I	leaith and l Death		ene 2006	30328
	District		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Lil	lian M. Sexto	n			September		10:45 P <sup>M</sup>
}	Examin	er	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			Suburban Hospita 5. Social Security Number 6. Se		last birth	Bethe	sda If Under 24 Hrs.	8. Date of Birth	Montgom	ery place (State or Foreign
	Funeral Director			□M 20 F 89		rs. Months Days	Hours Min.	(Month, Day, Y	ear) Cou	inois
<u></u>	pu 🕨		Usual Residence of Decedent		in Taur					
	ehov	,			ity, rown	or Location				10d. Inside City Limits 1 ☐ Yes 27 No
	28a-f	Directo	Maryland   Montgome	ery		Be 10f. Zip Code	thesda	100	J. Citizen of What Cou	
	3a or		4998 Battery Lar	ne #505			814		United Sta	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in I	J.S.	13. Was Decedent of H If Yes, specify Cuba			14. Race - Ameri	can Indian,
စ္တ	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f ehow ite Mudical Exammer misst be modified at		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 No If Yes, Give		1 ☐ Yes 2X No	Specify:	o riticari, etc.;	Black, White,	
5-0036	hours tural',	ed by	3 Widowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	162 [	Decedent's Usual Occup	ation	16	Specify: Whi	
5	n "na	Completed	(Specify only highest gra	de completed)	1 (	Give kind of work done of the contract of the	du <i>rina</i> most of wor.	king	ob. Kind of Business/iii	dustry
212	filed with Hygiene. other than	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	S	ecretary			School	
aryland 2121		Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	iden Sumame)	
<u> </u>	ould be Mental varked o	P	Francis R. Mear					Peterson		
ā Z	d 2 sh th and 7 le m traum		19a, Informant's Name/Relationship (7			Mailing Address (Street			30	
<u>ē</u>	Heali Heali tem 2		Ruth A. Sexton/Da 20a. Method of Disposition	nughter 20b.	Place of [	5 Waterford Disposition (Name of		liver Spri Date 20 ember	Ln Mary L c. Location - City or To	own, State
ē	Pages ent of nt: If i		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	, crematory or other place y Crematorium		, 2006 Be	ethesda, M	arvland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 le marked eny Injury or other traumatic evonce.		21. Signature of Funeral Service Licen	see		22. Name and Addres	ss of Facility	Eumoreal I	Bethe	sda-Chevy
	442 0 4		23a. Part 1. Enter the disease, or community shock, or heart failure. List only	plications that caused the dea	ith. Do no	7557 Wisco	nsin Avé	. , Betheso	da, MD 208	14-3501 · Approximate
1	Decisions		immediate Cause (Final	one cause on each line.	. 0.		100		,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a conse	quence of	wany)	Call	u.		
	Examiner		Sequentially list conditions	Court	Fre	e year	et F	ulue yope.	e	
	sit ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a / nse	quence of	):			(11	
19	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Sur Conse	quence of	ic an	dion	yope.	My	
58760,	icate be executed physicien and s the burial-transit	edicai E	•	d.					10	
_			IE EENAN E							
Box	eath certif attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	ancy al death	3 □Ectopic pregnancy			23d. Date of deliver	ery Day Year
P.O.	The law requires that the death certii sie hes been signed by the attending sege 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	death	5 Other (specify)			WOITET	Day
	that ti	, Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in (	the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
Division of Vital Records,	quires n sign uld be	ed by	nekolotic a	Ideno Carin	one	e Colo	n	1 🗆 Yes	200 3 □ Prot	oably 4 DUnknown
000	aw require is been sig 2 should b	Completed						24a. Was an	24b. Were auto	ppsy findings available
Ĕ.	The I	Com						autopsy performe	d? death? No 1 ☐ Yes	mpletion of cause of 2□ No
ita	cian: ertifica actor,	Be C	25. Was case referred to medical examiner?					th (Check only one)	\	
<del> </del>	Physic this c	P	1 ☐ Yes 2 ☑ No		ER/Outp		4 🗆 Huising II		ce 6 ☐Other (Specif	ý)
Ö	Attending Physician: r death. sctor: After this certifice by the funeral director, p	tion	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tir Inj	ury Wor	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
/ISI	Attendir death.	fica	3 Suicide 6 Could not be	28e. Ptace of Injury - At I	nome, farr			28f. Location (Stree	et and Number or Rura	al Route Number,
á	s after	Certification:	4  Homicide determined	building, etc. (Spec	ity)			City or Town, S	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificete hes completely filled in by the funeral director, pege 2	Medical (	29a. Certifier 112 Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, ation and/	death occurred at the tin for investigation, in my o	ne, date and place pinion, death occu	and due to the caus	se(s) and manner as s e and place, and due to	tated. o the cause(s)
	ro the vithin o the	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29d	. Date signed (Month,	Dey, Year)
	7		· Gul	MUSZI	1 K	2 0	231	70 Se	eptember 21	1. 2006
	20		30. Name and address of person who	completed cause of death (Ite	m 23a) (T	ype, Print)			_	
			Gita C. Bakshi, N			rgetown Roa	d, Bethe	sda, Mary	land 20814	
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2 5 200	32 Registrar's Sign	ature	poele				
			SEP Z & ZUU	O Note of Stranger	-					

LILIAN SEXTON SEPT. 20,2006 22:40,

			For State Registrar	State of Man	yland / Dep <i>Ce</i>	artment ertificate	of Healt of Dea	h and M		giene Reg. No.	2006	30329
	Physici		Decedent's Name (First, Middle, Last,						2. Date of De	ath Day	Year	3. Time of Death
E	/Medic		LOUIS LAWRENCE		₹.	T # 63 3		(2)	29	19	7001	
1.	Examin	er	4a. Facility Name (If not institution, give	21 - 1	I	4b. City,	own, or Locati	ion of Death	MIN	4c.	County of Dea	tn
4			5. Social Security Number 6. Se	h HOSO1-	n yrs. last birthday	) If Under	1 Year   If Un	nder 24 Hrs.	8. Date of Bir	th	N/A 9. Bin	thplace (State or Foreign
T.	Funeral Director			M 2□F	77 Yrs.	Months	Days Hou	ırs Min.	(Month, Da			RYLAND
	p _ g		Usual Residence of Decedent							.,,,,,		
	show	_	10a. State 10b. County		0c. City, Town or L PARKVI							10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
	he M	ecto	MD BALTIMOI	1E	LAMIVI		Codo			10- 00	zen of What Co	-
	with t	급	10e. Street and Number 8112 BONAIR ROAD			10f. Zip	21234					ountry ?
	ns 23	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Deced	ent of Hispanio	Origin? (Spe	cify Yes or No		ISA 14. Race - Ame	erican Indian,
(0	ifter d	F	1 ☐ Never Married 2 ☒ Married	Armed Forces?  1 Yes 2 YNo		If Yes, spec	fy Cuban, Mex	kican, Puerto	Rican, etc.)		Black, Whit	e, etc.
80	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Spe	сту:			Specify:	VHITE
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examir ar mush be notified at	Completed	15. Decedent's Edu (Specify only highest grad		(Giv	edent's Usua e kind of wor	k done during i	most of worki	ng		nd of Business	
12	han han	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us	e retired) SERVIC	E MANIA	CFD		NOBILE	SALES &
2	e filed within al Hygiene. i other than " vent, the Me		12TH GRACE 17. Father's Name (First, Middle, Last)		AUTON	ODILL			(First, Middle			
and	d be f	o Be	LOUISE CHARLES S	CHOTT					F. KRI			
Maryland	s 1 and 2 should be 1 f Health and Mental I ltem 27 is marked o other treumatic eve	은	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mai	ing Address	(Street and Nu	ımber or Rura	I Route Numb	er, City or	r Town, State,	Zip Code)
ž	alth a		MARY ELLEN SCHOTT	/WIFE	8112	BONA	R ROAD	BALT	IMORE,	MD	21234	
ore,	of He of He roth		20a. Method of Disposition 1 ☑ xurial 2 ☐ Cremation 3 ☐ F		20b. Place of Disp cemetery, cre	osition (Name matory or ot	ne of ther place)		Date	20c. Lo	cation - City or	Town, State
Ĕ	Pag ment ent: I		4 Donation 5 Other (Specify)	iamovar nom State	PARKWOOD	CEMET	CERY		/2006		TIMORE	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tre		21. Signature of Funeral Service Licens	99			d Address of F					HOME, P.A.
			They we	Conar	1		JOCH RA			<u>-</u>	MD 212	Approximate
1			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	e death. Do not er			*	n respiratory a	iiest,		Interval Between
	Pnysician /Medical		disease or condition resulting in death)	Myoca	Rdial	In	tarca	m				hours
	Examiner			Due to (or as a c	onsequence of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):							
d	cuted nd ransit	Examine	that initiated events	c								
Ö,	e exe		resulting in death) Last	Due to (or as a c	onsequence of):							
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	dicai		d								
9 x	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy						23d. Date of de	livery
Вох	atten atten I for u	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death 3	☐Ectopic pre☐ Other (spe				-	Month	Day Year
0	를 들는 유	hysi	1 Yes 2 No 9 Unknown	9□ Unknown								
٦,		by P	Part II. Other significant conditions co	ntributing to death but i	not resulting in the	underlying ca	ause given in P	art I.	23e. Did	obacco u	se contribute to	the cause of death?
Records,	w requires been sign should be	ed							<b>X</b>	Yes 2	□No 3□Pi	robably 4 Unknown
ecc	S. C. S. C. S. C. S. C. S. C. S. C. S. C. S. C. S. C. S. C. S. C. S. C. S. C. S. S. C. S.	Completed							24a. Was	psy	prior to	utopsy findings available completion of cause of
<u> </u>	ate pag	S S							perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	20 No
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. F	Place of Death	(Check only	one)		
of	Phys this ral dir	<u>۲</u>	1 Yes 2 No 27. Manper of eath	1 L Inpatient	28b. Time		8c. Injury at		me 5 Resi		Other (Spe	icify)
on	ding h. After fune	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	'ear) Injury	м	Work? 1 ☐ Yes		200, 2000, 100	now inqui	y 000anoa	
Division	Attending r death. ector: After by the fune	ertification;	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, s	treet, factory	, office					ural Route Number,
á	s afte	Cert	4  Homicide	building, etc.	(Эрөсілу)				City or To	wn, State	,	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral			sician: To the best of e								
	the hin 24 the F	Medical	one)	and manner state	d.							
	To Too	2	29b. Signature and title of certifier				License numl				e signed (Moni	
7	110		Munit / TX		ub //b-= 00 : =		1301	7 >		JEP	securit	17,200
	20		30. Name an address of person who o	mpleted cause of dea	th (Item 23a) (Type	(20°	Ranias	Box	lours P	B	el finer	20, 200 ce 21239 re, Marylan
Si	Sta	ite	31. Date filed (Month, Day, Year) SEP 2 5 2008	2. Registrar's	s Signature	40	,	10000	eome(	.,,,		, was the
*	Regist		SEP 2 5 2006	Alleria	A Appe	der.						

State of Maryland / Department of Health and Mental Hygiene For Stete Registrer 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day SEPTEMBER 23 2006 Month AUDREY STEWART **Physician** ANNE 11:34 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days Hours Director 216-24-9742 Dec. 22, 1928 Maryland Usual Residence of Decedent pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examination must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1425 Barrett Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo White þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 12 Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hafele Laura Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Stewart Daughter 5362 28th Street NW; Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9/25/2006 Catonsville, Maryland 21. Signatur of Furna al Service License 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** 6 DAYS /Medical Due to (or as a consequence of): Examiner SEPSIS 6 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (37 as a consequence of) Hospital or Attending Physician: The law requires thet the death certificate be executed attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIFFICILLE 3 ☐ Probably 4 ☑ Unknown Completed FIBRILLATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No : After this certification of the funeral director, it Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Mnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) RESIDENT RES DOI idu J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, Year) SEP 2 5 2006 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrer	State of M	/larylan	d / Depa <i>Cei</i>	artment of H	lealth and Death	l Mental Hyg	giene 20 (	06 30331
	Dhysisi		1. Decedent's Name (First, Midd	lie, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medic		SADLE			-HUCH			SEPTER		
	Examin	er	4a. Facility Name (If not institution	-			4b. City, Town, o			4c. County of	
			MURTHWEST	HUSPITAL		to a distance of	If Under 1 Year	LISTOW LISTOW			MORE
	Funeral		5. Social Security Number 091-07-9738	6. Sex 7. / 1 ☐ M 2 ☐ F	89 (In yrs. 1	last birthday) Yrs.	Months Days	Hours M		1 0 1 7	Birthplace (State or Foreign Country) MASS
	Director		Usual Residence of Decedent	^	03				01/13/	1311	11/100
	/land		10a. State 10b. Count	y	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Man Fish	ğ	MD	N/A		BALT	IMORE				1 X Yes 2 □ No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	
	th wit	alD	5833 PARK HEI	GHTS AVENUE	#213			21215			USA
	ems ems	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U. \$?	S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
98	or It		1 Never Married 2 Ma	KV Cire	No	1		Specify:		Specify:	WHITE
Ö	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Medical Exercites must be notified at	d by	3 X Widowed 4 □ Divorce		S:	   100 December	tantla Haval Ossua	ation		16b. Kind of Busin	
구	"nat	Completed	(Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of v d)	vorking	100. KING OF BUSI	less/industry
72	withii ene. then	ᄩ	Elementary/Secondary (0-12)	College (1-4d	r 5+)		EWIFE	,		OWN HOME	
0	filled Hyg other ent,	BeC	17. Father's Name (First, Middle	, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumame)	
/lan	uld be Menta wrked ntic ev	ToB	SAMUEL			LICH	ITER	PAUL	INE		STEINBERG
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other then "netural", or items 23e or 28e-1 show other treumatic event, the Medical Exertiner must be notified at		19a. Informant's Name/Relation JACOB SCHUCHM						Rural Route Numbe VE BAL		
e,	1 and Healt em 2 ther 1		20a. Method of Disposition	7 3011	20b. P	1 12:			Date	20c. Location - Ci	
٥	nt of In the		1 X Burial 2 ☐ Cremation		, a	emetery, crer	sition (Name of natory or other place CHIM ANSH		22/2006		ALE, MD
Baltimore,	artme ortani injury		* 4 ☐ Donation 5 ☐ Other (: 21. Signature of Funeral Service		Ado				SOL LEVIN		
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		Robert	Two-	$\supset$						E, MD 21208
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause of only one cause on each	ed the death line.	n. Do not ent	er the mode of dyin	g, such as card	iac or respiratory ar	rest,	Approximate Interval Between
S.	Physician		Immediate Cause (Final disease or condition		nnev.	morea					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	s a consequ						7
	Examiner		Sequentially list conditions, if any, leading to immediate	b							
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Discuss or injury	d Due to (or a	as a consequ	uence or):					
	and and Il-tran	Examin	that initiated events resulting in death) Last	c. Due to (or a	as a consequ	uence of);					=
8760,	death certificate be executed e attending physician and d for use as the burial-transit	<u>e</u>									
687	ficate p physics the	Physician/Medical		0.							11
Box (	eath certific attending p I for use as t	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ter			23d. Date of	of delivery
	death e atte d for	Cia	in the past 12 months? 1 ☐ Yes 2 ②No	1☐Live birth 4☐Pregnant	at time of de		Ectopic pregnancy Other (specify) _	·		Month	Day Year
P.O.		hys	9 🗆 Unknown	9□Unknown							
	requires that the een signed by th hould be detache	by P	Part II. Other significant condit	tions contributing to death	but not resi	ulting in the u	nderlying cause giv	en in Part I.			ite to the cause of death?
ğ	v require been si should l								_ 1 U Y	′es 2 □ No 3	Probably 4 Hunknown
of Vital Records,	aw 1s b	Completed							24a. Was	an 24b. We	re autopsy findings available or to completion of cause of
<u> </u>	The ate h page	ĕ							perfo	rmed? dea	th? Yes No
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medic examiner?						eath (Check only o	ne)	
7	S S D	မ	1 ☐ Yes 2 ☑No			ER/Outpatier		4 🗀 14013111	Home 5 ☐ Resid		
ň		io	27. Manner of Death 1 S □ Pend		Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe i	now injury occurred	
isio	Attending r death. ector: Afte by the fune	icat	3 Suicide 6 Could		Injury - At ho	ome farm etr	eet, factory, office	165 2 110	28f Location (5	Street and Number	or Rural Route Number,
Division	or Attendater death Director:	ertification;	4 Homicide deten	mined 200. Place of building,	etc. (Specify	y)	oat, ractory, office		City or Tox	m, State)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	ledical C		ing Physician: To the be I Exeminer: On the basis							
	To the h within 24 To the F complete	Med	one) 29b. Signature and title of certifi	and manner	stated.		29c. Licens	e number		29d. Date signed (	Month, Day, Year)
	- s - s		) Da	inton Ma	2		Do	059736		hand .	22 2001
n			30. Name and address of person			1 23a) (Type,		- / 11/	-	Milare	URT ROAD
	)			tson mo	~	ORTHW	EST Itos	PITAL	5401	OLD CO	URT ROAD
	Sta Registi		31. Date filed (Month, Day, Year SEP 2 5 2	7) 32. Regi	strar's Signa	ture	of s				
	riegisti	ш	01.001	The state of the s		0 1					

	т.	Decedent's Name (First, Mide acqueline Rut								2. Date of De Month Septem	Day	1, 200	3. Time of Death 6 11:20 PM M
/Medical Examiner	_	. Facility Name (If not institution		ber)		4b. City,	Town, or	Location o	f Death	-		County of Dea	
. Sec.		pper Chesapea	ke Hospital	L			E	Bel Ai	.r		Har	ford	
Funeral Director		Social Security Number 16-30-1510	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. <b>72</b>	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 03/08/	th 1 <i>y, Year)</i> 1934	9. Bir Co IMID	thplace (State or Foreign ountry)
200	_	ual Residence of Decedent a. State 10b. Count	tv	10c. Cit	ty, Town or Lo	ncation							10d. Inside City Limits
or other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director					est Hi								1 Tes 2 No
Director	10	e. Street and Number				10f. Zip	Code				10g. Citize	en of What Co	ountry?
<u></u>		09 Forest Val	ley Drive			210					Unite	ed Sta	tes
by Funeral		. Marital Status  1 □ Never Married 2 □ Ma 3 □ Widowed 4 🔀 Divorce	If Yes Give	ces? 2 <mark>⊠</mark> No ∍	l.S. 13.	Was Deced If Yes, spec	ofy Cuba	ispanic Origin, Mexican	gin? (Spe Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify Whi	e, etc.
Completed		15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed)  College (1-	40r 5+)	(Give	dent's Usua kind of woi DO NOT us	rk done d	durina mast	of worki	ng	16b. Kind Bank:	d of Business ing	/Industry
E		12	College (1-	401 34)	Clerk	Typi	st						
To Be C	17	Robert Blackb						18. Mother Emma		(First, Middle hm	, Maiden S	Sumame)	
	15	9a. Informant's Name/Relation Mrs. Wendy Higg		:		-				<i>I Route Numb</i> phrata,			Zip Code)
	20	a. Method of Disposition  1		State	Place of Disponentery, creametery, creametery	matory or o	ther plac	· 1	S	ep 5		ation - City or	Town, State
DUCE.	2	1. Signature of Funeral Service		MOOS	86 E	2. Name an <b>remat</b> i	d Addres	ss of Facility		Altern rive B			rvland
the burial-transit neuron leading lead	d re	shock, or heart failure. Linedate Cause (Final isease or condition sulting in death)  equentially list conditions, any, leading to immediate ause. Enter Underfying ause (Disease or injury at initiated events sulting in death) Last	a Due to (c	or as a consec or as a consec or as a consec	quence of):	eumo			DROVED	BY MEDICAL	AMINER		Interval Between Onset and Death
dicai			d.				CER						
dicai		FEMALE: 3b. Was decedent pregnant in the past 12 months? 1  Yes 2  Hoo 9  Unknown		nth 2 ∏ Feta ant at time of c	al death 3	⊒Ectopic pr ⊒ Other (sp	egnancy					3d. Date of de Month	livery Day Year
Physician/Medical	1F 2:	Bb. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unkno	nth 2 Feta ant at time of c wn ath but not res	al death 35 death 55	Other (sp	egnancy ecify)				23 obacco use	Month e contribute to	
pleted by Physician/Medical	1F 2:	Bb. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live bin 4 Pregna 9 Unknown tions contributing to de	nth 2 Feta ant at time of c wn ath but not res	al death 35 death 55 sulting in the u	Other (sp	egnancy ecify)			23e. Did l	obacco usi Yes 2 2	Month e contribute to No 3 Pri 24b. Were au prior to death?	Day Year the cause of death?
Be Completed by Physician/Medical	Pr 2:	Bb. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 □ Live bil 4 □ Pregna 9 □ Unkno	nth 2 Feta ant at time of c wn ath but not res	al death 35 death 55 sulting in the u	Other (sp	egnancy ecify) ause givi	en in Part I. 26. Place	of Death	23e. Did I  1   24a. Was auto perfc 1 Yes	23  cobacco us: Yes 2 an psy psy primed? 2 a No	Month e contribute to No 3 Pr  24b. Were at prior to death 1 Yes	Day Year  the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
To Be Completed by Physician/Medical	Pa	3b. Was decedent pregnant in the past 12 months?  1   Yes 2   Wo 9   Unknown  art II. Other significant conditions are referred to medic examiner?  1 (XYes 2)	tions contributing to de	nth 2 Feta Int at time of c wm  ath but not res	al death 35 leath 55 suffing in the u	Other (sp	egnancy ecify) ause give	en in Part I. 26. Place er: 4 □ Nui	of Death	23e. Did l 1	23 Tobacco usi Yes 2 22 an psy Trimed? 2 12 No one	Month e contribute to 3  Pr 24b. Were au prior to death? 1  Yes	Day Year  the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
pleted by Physician/Medical	Pa	3b. Was decedent pregnant in the past 12 months?  1   Yes 2   Wo 9   Unknown  and II. Other significant conditions of the conditions of th	tions contributing to de la la la la la la la la la la la la la	int at time of common at the but not respectively. It is a specific partial to the common at the but not respectively. It is a specific partial to the common at the commo	at death 35 death 55	Other (sp	egnancy ecify)ause given	en in Part I. 26. Place er: 4 □ Nui	of Death	23e. Did la la la la la la la la la la la la la	23  Tobacco us: Yes 2 2 an an an an an an an an an an an an an	Month e contribute to 3 Pri 24b. Were au prior to death? 1 Yes  Other (Spe occurred a pede	Day Year  the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of  2 No
ed in by the further at director, page 2 should be detached to use as the but Certification: To Be Completed by Physician/Medical	Pr 2:	3b. Was decedent pregnant in the past 12 months?  1	tions contributing to de local y place ding stigation dining dining mined local y place building Road	ath but not res  patient 2  finjury , Day Year)  /1980  of Injury  of Injury  best of my known	BER/Outpatier  28b. Time of Injury  Unknown, starm, st	other (sp	egnancy ecify)  ause give  A Other  Be. Injun Worl  I , office	26. Place er: 4 Nur y at k? Yes 24 h	of Death	23e. Did to the analysis of the control of the cont	obacco using the second of the	Month  e contribute to  3 Pi  24b. Were an prior to death? 1 Yes  Other (Spe occurred a pedia pe	Day Year  of the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of security)  estrian  ural Route Number,  and near  stated near  stated near
edical Certification: To Be Completed by Physician/Medical	Pr 2:	3b. Was decedent pregnant in the past 12 months?  1	tions contributing to declared in the mined later and mann later and later a	inpatient 2   Feta form  ath but not res  form	BER/Outpatier  28b. Time of Injury  Unknown, starm, st	other (sp	ause given  A Other  Bec. Injun  Worl  I   //, office  at the tim, in my of	26. Place er: 4 □ Nur y at k? Yes 24 □ Nur pinion, deat	of Death	23e. Did to the analysis of the control of the cont	an psy armed? 2 P No one dence 6 how injury twas the cause of the caus	Month  e contribute to  3 Prior to death? 1 Pres  Other (Spe occurred a pedia	Day Year  to the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of  2 No  cify)  estrian  ural Route Number,  ard near  as taled.  to the cause(s)
pleted by Physician/Medical	Pr 2:	3b. Was decedent pregnant in the past 12 months?  1	tions contributing to declared in the mined later and mann later and later a	inpatient 2   Feta form  ath but not res  patient 2   fliqury , Day Year)  /1980 of Injury - At h g, etc. (Speci.  Way  best of my knows of examina	BER/Outpatier  28b. Time of Injury  Unknown, starm, start,	other (sp	ause given  A Other  Be. Injun  Word  I office  at the tin  in my office  License	26. Place er: 4 Nur y at k? Yes 24 N ne, date and pinion, deat e number	of Death	23e. Did to the sauto perfect of the sauto perfect	obacco using the second of the	Month  e contribute to  3 Price to death? 1 Yes  Other (Spe occurred a pede a p	Day Year  to the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of  2 No  cify)  estrian  ural Route Number,  ard near  as taled.  to the cause(s)

DHMH 17 Rev 1/2001

			1- State of Maryland / Dep	ertificate of Death	lental Hygiei	401	06 3033
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	/Medic		MILTON L. WELLS		SEPTEMB:	ER 21,2	006 8:17₽M
	Examin	er	4a. Facility Name (If not institution, give street and number)  2419 LODGE FARM ROAD	4b. City, Town, or Location of Death  EDGEMERE		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIM 9. Bir	thplace (State or Foreign ountry)
	Director		218-26-7761 <sup>1</sup> X <sup>M 2</sup> 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 2-29-19	32	VA
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary I ah	to	MD BALTIMORE EDGE	MERE			1XXYes 2 □ No
	or 28s	Olrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	ountry?
	ath wi	ral	2419 LODGE FARM ROAD	21219		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene.  Department of Heatin 27 is marked other then "natural", or items 23a or 28a-f ahow any injury or other traumatic avant. It a Medical Erac. Let meat be inclided at once.	y Funeral Director	1 Never Married 2 Married 1 TYes 2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	2 hour	Completed by		edent's Usual Occupation	16b	. Kind of Business	BLACK
215	hin 72	plet	(Specify only highest grade completed) (Giv	e kind of work done during most of work. DO NOT use retired)	ing	. rang or business	vindustry
N	ed wit	Con		RIVER		ALLIANO	CE
Maryland	ntal H ad oth	Be	17. Father's Name (First, Middle, Last) ERNEST WELLS		(First, Middle, Maid		
<u>Z</u>	should nd Mei marki matic	7		ing Address (Street and Number or Rura	LEE BAIL		Zin Code)
	1 and 2 : Health ar tam 27 is		EMMA DEAN WELLS/WIFE 241  20a. Method of Disposition 20b. Place of Disp	9 LODGE FARM RO	AD BALT	IMORE,	MD 21219
Baltimore,	Pages nent of I int: If It, iry or o		LABuriai 2 Cremation 3 Chemoval from State	WILLE CEM. 9-2		OWNSVII	
alti	permit. Departm Importa any inju			2. Name and Address of Facility JAM			
<u> </u>	8858		7-10-1	701-31 LAURENS		rimore,	MD 21217
			23a. Party. Enter the disease, or complications that caused the death. Do not er strock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
À	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Meltantate Cause (Final disease or condition resulting in death)	ung cancer.			
	Examiner		Sequentially list conditions b.	/			
7	o ii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
4	xecute and Il-tran	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transit	cal E	d				
9	rtificat ng phy as th	Medi	Is seems.				
Box 6	eath certific attending p	an/N		⊒Ectopic pregnancy		23d. Date of de Month	livery Day Year
P.O.	Attending Physician: The law requires that the death certificate be executed to death. Tobath. sctor: Attenthis certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	1 Yes 275 No 4 Pregnant at time of death 5	Other (specify)		Workin	Day 16ai
<del>ر</del> .	s that i	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ıds	w require been sig should b				1 Des	2 No 3 P	robably 4 Unknown
Records,	elawre hasbe je 2 sh	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
四田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田	n: The icate !				performed		2 No
⋚	sicial s certifinecto	o Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death		2 F 2 11 12	
ם נ	g Phy er this ieral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	A Nuising Ho	Residence 28d. Describe how in		city)
Sior	endin eath. or: Aff	atlo	2 Accident investigation	M 1 Yes 2 No			
	무용동료	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Re ate)	ural Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, deal (Check only one)  2. Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a ovestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	s stated.  to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Mont	h, Day, Year)
)			Jugar (ell no	121242	9/3	25706	
	ex /		3) Name and defess of person who competed use of death (Item 23a) (Type	Print) 4924 Campbel	1 But	/	
1	Sta	te	31. Date filed Month, Day, Year)  32. Registrar's Signature	Balto, Will 3	11236		
	Registr		SEP 2 5 2006	E .			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 30334 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month Day **Physician** September 20,2006 6:37 P M S. Weber /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel 2506 Amber Orchard Court #301 Odenton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 **X**M 2 ☐ F Months Yrs. Director 70 5, 1935 Connecticut 465-48-0795 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other then "neturei", or itams 23a or 28e-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits It e Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2506 Amber Orchard Court #301 21113 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Asst. Professor of Biology Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Karl J. Weber Hildegard Kuhner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine S. Weber/wife 2506 Amber Orchard Court #301, Odenton, MD 21113 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ott cometery, crematory or other place)
West Arundel
Crematory 1 Burial 2 Cremation 3 Removal from State Sept 2006, \* 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P. 1411 Annapolis Road, Odenton, MD 21113 21. Signature of Funeral Service License menuco mod 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 months Privoician Mantle Cell Lymphoma /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√√ No 24a. Was an has page 2 autopsy performed? certificate 2 **X**No 1 ☐ Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 5 Pending 1X Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 X certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0023601 Sept. 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward J. Lee 11065 Little Patuxent Pkwy, Columbia, MD 21044 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 30335 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Woodly Geraldine Yeer **Physician** Month Woodley 09 <del>Ceraldine</del> 23 06 4:00p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1608 Burnwood Road Baltimore N/A 8. Date of Birth (Month, Day, Year) 04 13 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. Months Days Hours 1 M 2 K Director 86 20 064-12-2576 MA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County rel', or items 23a or 28a-f shov Examirer must be notified at 1 Yes 2 □ No MD NA Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1608 Burnwood 21239 U.S.A. Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel', or iten any injury or other traumatic event, the Medical Examples once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Dept. Store Manager na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown 2 Ada Coles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Burnwood Road, Baltimore, Md 21239 Deborah Drummer-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 4 Donation Metro Crematory INC 9/26/06 Baltimore, 21. Signatur 22. Name and Address of Facility of Funeral Service Licensee 23a. Part1. Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. March F/H West Baltimore, Ma 21215 Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a I for use as the burial-Division of Vital Records. P.O. Box 68760. Physician/Medical IF FFMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 Who the 9☐ Unknown 9 Unknown ģ Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 → 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s certificate 1 Yes 2 No 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Tesidence} \) 6 \( \text{Other} \( \text{(Specify)} \) Hospital: 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred Certification; 28b. Time of 28c, Injury at Work? After 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 20396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raver Davism 5601 head 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar SEP 2 5 2006

06-07098

#### Please Type or Print in Black Indelible Ink

Devin Wright State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0215 hrs **Medical Examiner** September 20, 2006 Wright Antoni Devin 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 701 Gold Street If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. 8irthplace (State or 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** oreign Days Hours Min Director 79 Country) 216-96-5106 1 X M 2 0 14 MD 26 Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Aut. 10a State 10b County 1XXYes 2 No items 23a or 28a-f show ast be notified at once. Baltimore NA MD death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 21217 U.S.A. 1317 North Stockton Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1X Never Married 2 Married Yes 2 X No f Yes, Give Year Black Divorced 1 Yes 2X X No specify. Specify Widowed "natural", 3 or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) it Pages 1 and 2 should be filled within 72 hou runn to f Health and Mental Hygiene rant: If liem 27 is marked other than "natu or other traumatic according to the property of the page 1. Completed Flementary/Secondary (0-12) College (1-4 or 5+) Unemployed Unemployed llth grade na 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Vicki L. Johnson Ronald Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number of Rulai Route North Stockton St., Baltimore, Md Vicki Johnson-Mother 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a Method of Disposition Baltimore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State permit Pages
Department of
Important: I Druid Ridge 9/26/06 Pikesville, Md Donation 5 Other Specify Signatur at Fur eral Service Licensee, 22 Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, Part I. Enter the disease, or complication failure. List only one cause on each in hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical a gunshot wound of neck Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and cian/Medical fing physician as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) has been signed by the att 2 should be detached for Physi 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes director, 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital 1 Inpatient 2 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 V Other: Scene this FR/Outpatient 3 1 V Yes funeral o 28a. Date of Injury FOUND: Day, Year) After 1 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work' Certification: Subject shot FOUND: Natura Pending 1 Yes 2 ✔ No Director: d in by the f after death Sep 20, 2006 0000 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 701 Gold Street, Baltimore, MD determined (Specify) Park/Recreation Area Funeral 4 V Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 and manner stated 29b. Signature 29c License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. September 20, 2006 JR. Name and address of person who o use of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State

Registra

P 25 2006

Malera

06-07049

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Jerry Wendler 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1030 hrs F. Medical Examiner Jerry Wendler September 18, 2006 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) - set 3726 Elmora Avenue Baltimore 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreian Months Days Hours Country) Maryland Director Nov. 20, 1957 216-72-9355 48 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 7 is marked other than "natural", or items 23a or 28a-f show injury or other trannatic event, the Medical Examiner must be notified at ouce. Baltimore N/A Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 u. s. A. 3726 Elmora Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No White Divorced If Yes, Give Year or Dates: Yes 2 X No specify: Specify: 3 Widowed 2 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Railroad - Shuttle Driver 12th Grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joan Frank Be Karl Wendler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3726 Elmora Avenue, Baltimore, Maryland 2<u>1</u>213 Joan Wendler (Mother) 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 9/20/2006 Baltimore, Maryland Bayview Crematory Donation 5 Other Specify 21. Signature of Funeral Se ince Licens ee 22. Name and Address of Facility Schimunek Funeral Home Inc 8 3331 Brehms Lane, Baltimore, Maryland Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease **x**aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ted for use as the burial - transi The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be be deta ⋧ 1 Yes 2 No 3 Probably 4 ✔ Unknown Obesity, Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 2 No page certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Residence 6 🗸 Other: Scene Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 1 🗸 Yes မ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Yea 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Yes 2 No Director: Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) filled (Specify) Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within ? To the I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 18, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 5 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc. 16a, 17, 19a per fh e860, 10-23-06 vt. State of Maryland / Department of Health and Mental Hygiene 2000. Reg. No. 2006 30338 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jefferson Woodward Lewis Month Day Year **Physician** 15 AM 2006 sept /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anna Dolls Anne Hrunde Hrunde thne 1cal renter If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Hours Min 100M 2□F Director 213-78-9497 teb Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Hnnas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 JSA 21403 Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 (Dives 2 No Now) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Drive 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than na eny injury or other traumatic event, It a Madia 2006. Driver College (1-4or 5+) Elementary/Secondary (0-12) 10 trans Do Woodward 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Toice ပ eurs 19a. Informant's Name/Relationship (Type) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 31403
Date 20c. Location - City or Town, State 318 State St Vacouur o / wife lana 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □ Burial 2 □ Cremation 3 □ Removal from State Metro Crematory | 22. Name and Address of Pacility 9-28 4 □Donation 5 □Other (Specify) -06 Balto 21. Signature of Funeral Service Licensee AM 1232 Midvalley Dr Jessup, PA 18434 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit been signed by the attending physicien and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? perdensin 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 100 Diabe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2□ No 2 1 No 1 Yes 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient Certification: To 1 Tes 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred after death. Director: After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours after To the Funeral Dis 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOWARZO Vouns

SEP 2 5 2006

31. Date filed (Month, Day, Year)

MO

32. Registrar's Signature

D00058297

Anne Arnold Medial Confor Annaprilis MD 21401

09/16/

06

			For State Registrar	State of	Marylar	nd / De <i>C</i>	partment of ertificate of	Health and Death	Mental Hy	giene, Reg. No.	2006	30339
	Physici /Medic		Decedent's Name (First, Middle, Eleanor Warf:	Last)					2. Date of De	ath Dav	0 2006	3. Time of Death 4:23p M
	Examin		4a. Facility Name (If not institution, 2615 Manchester	•	ber)		Westmi				County of Death	
1	Funeral Director		212-24-5229	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	last birthda Yrs.	Months   Days			iy, Year)	9. Birthp Coul MD	place (State or Foreign ntry)
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County MD Carro	11		ty, Town or					1	10d, Inside City Limits 1 ☐ Yes 2 No
	s or 28a-	Funeral Director	10e. Street and Number 2615 Manchester	Road			10f. Zip Code 21157			10g. Citiza	en of What Cour	ntry?
350	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or items 23a or 28a-f show says figury or other traumatic event, the Madical Examinar must be nutilised at ADDS.	by	11. Marital Status  1 Never Married 2 Marrie  3 Nover Married 4 Divorced	12. Was Dece Armed For 1  Yes If Yes, Give Year or Da	ces? 2 No	J.S. 1	3. Was Decedent of If Yes, specify Cu	ban, Mexican, Pue	Specify Yes or No nto Rican, etc.)		4. Race - Americ Black, White, Specify: whi	etc.
9500-6121	within 72 hou ene. than "nature he Madical E	Completed	15. Decedent (Specify only highest Elementary/Secondary (0·12)	s Education t grade completed)  College (1-	4or 5+)	(Gi life	cedent's Usual Occi ive kind of work don a. DO NOT use retir	e durina most of wo	orking		d of Business/In	
yland z	lid be filed view lental Hygie ked other i	To Be Co	17. Father's Name (First, Middle, L Lee Owings Wart	ast)					me (First, Middle r Branch	, Maiden S	Gumame)	
, магу	and 2 shou alth and M 27 is mar or traumat		19a Informant's Name/Relationsh David White (sor				Manchest					
saltimore	Pages 1 and nent of He ant: If item ury or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		****	cemetery, c	sposition (Name of crematory or other pi eld Cemet		Date 3-06		ation - City or To ${\sf sville}$ ,	
Ball	permit. Departr Importu eny luj		21. Signature of Funeral Service L  Pouge Olougest	icensee Jerhoer	-		22. Name and Add P.O. Box					Chapel
	Physician /Medical Examiner		23a. Part1. Enter the disease, or a shock, or heart failure. List of mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a	ch line.	ten		ning, such as cardia		rrest,		Approximate interval Between Onset and Death
8/00,	ficate be executed physicien and s the burial-transit	Icai Examiner	iff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a conse							
O. Box 6	death certi e attending id for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ⊠Unknown		nth 2 □ Fet antattime of	el death	3 ⊟Ectopic pregnan 5 ⊟ Other (specify)	су		23	3d. Date of delive Month	ery Day Year
ras, r	requires that the een signed by th hould be detache	þ	Part II. Other significant condition	ns contributing to de	ath but not re	sulting in the	a underlying cause g	iven in Part I.		tobacco us Yes 2□		he cause of death?
а несога	The lay ate has page 2	Completed									24b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpat	tient 3□ DOA C	thor	eath <i>Check only</i> of Home 5 <b>A</b> Resi		Other (Specif	6.1
on of	i je	<del> -</del>	27. Manner of Death  1 Senatural 5 Pending 2 Accident investig	28a. Date of		28b. Time Injur	e of 28c. In		28d. Describe			,,,
Division		Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At I g, etc. (Speci	iome, farm,	street, factory, office	9	28f. Location ( City or To		Number or Rura	al Route Number,
	ne Hospitel or n 24 hours afte ne Funeral Dir bletely filled in	edical		g Physician: To the Examiner: On the ba and mann	sis of examin							
	To the within To the Comple	×	29b. Signature and title of certifier					3725		29d. Date	signed (Month.	Day, Year)
	4		30. Name and address of person v	who completed cause	of death (Ite	m 23a) (Typ	oe. Print)		ninit	er	MD.	2/157
1	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 5	2006	ngistrar's Sign	ature	Road					_

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryla		partment ertificate				giene Reg. No. 2 (	006	30340
	Physici /Medio	al	Decedent's Name (First, Middle, Last)     Diane Eli  4a. Facility Name (If not institution, give str	zabeth Whit	e	Ab Cibra	Town or I	ocation of Deat	2. Date of De Month Septem	Day	2006	3. Time of Death 3.4/AM
	Funeral	er	Frank Sg/1 5. Social Security Number 6. Sex	vare Hos	Spital s last birthda Yrs.	y) If Under Months	OSC	If Under 24 Hrs. Hours Min.	8. Date of Bir	th v. Year)	9. Birthplac	e (State or Foreign
	Director		212-42-3255  Usual Residence of Decedent  10a, State 10b, County		City, Town or				Sept.	0, 1944		. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow r nust be notified at	ector	MD Baltimo	re	В	altimo:				10g. Citizen of V	Mhat Country	1 ☐ Yes 2 ☐ No
	23a or	Funeral Director	46 Baltistan Court				212			U	SA	
<b>38</b>	hours after dea tural', or Itame	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2Y No If Yes, Give Year or Dates:	U.S. 1	3. Was Deced If Yes, spec		panic Origin? (S , Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Specify	e-American ck, White, etc v: Whit	
1/hit	n 72	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	(Gi	cedent's Usua ive kind of wor b. DO NOT us ispatcl	rk done di se retired)	tion uring most of wo	rking	16b. Kind of B		,
Naryland	s 1 and 2 should be filed within the Health and Mentai Hygiene. Item 27 is marked other than other traumatic event, the Mentain than the Mentain the Mentain the Mentain the Mentain the Mentain the Mentain the M	To Be C	17. Father's Name (First, Middle, Last) Gerald White						me (First, Middle Amoss	Maiden Suman	10)	
Man	and 2 shoul saith and M n 27 is mari		19a. Informant's Name/Relationship (Type Mr. Nick Rossi (	e, <i>Print)</i> Friend)		-			<sub>ural Route Numb</sub> timore,			ode)
191	ages 1 and 3 nt of Health : If item 27		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		sposition (Namerematory or of one)			Date 2/2006	20c. Location - Sykesvi		
D19	permit. Pages Department of I Important: If its eny injury or o	8 8	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses						E & CHAI 84 (410			
8760,	Physician Physician and Physic	dicai Examiner	23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause fusease or injury that initiated events resulting in death) Last  d.	Due to for as a cons	equence of):	Sto	e of dying	, such as cardiau	c or respiratory a	rrest,	In	pproximate terval Between nset and Death
P.O. Box 6	thet the death certific ed by the attending pl detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death	3 □Ectopic pr 5 □ Other <i>(sp</i>					te of delivery onth Da	ay Year
	w requires thet II been signed by should be detac	ğ	Part II. Other significant conditions conti	nbuting to death but not i	resulting in the	e underlying c	ause give	n in Part I.	23e. Did 1	obacco use con Yes 2 No	tribute to the	
al Reco	ician: The law re- certificate has bee ector, page 2 sho	Completed							1 ☐ Yes	psy prmed? 2 No	prior to comp death?	y lindings available letion of cause of No
Division of Vital Records,	To the Hospital or Attending Physician: The law requires thet the death certificate within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	ation: To Be	25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending investigation	spital: 1 □ Inpatient 2 28a. Date of Injury (Month, Day Year			8c. Injury Work	r: 4 🗆 Nursing H	ath (Check only Home 5 Resi			
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm,	street, factory	/, office		28f. Location ( City or To	Street and Numb wn, State)	per or Rural R	Route Number,
	e Hospii 24 hour e Funer	edical		cian: To the best of my left: On the basis of exam and manner stated.								
	To th To th comp	Me	29b. Signature and title of certifier	k		290	:. License	number	1	29d. Date signe	d (Month, Da	y, Year)
	10		30. Name and address of person who con	npleted cause of death (I	tem 23a) (Tyl	pe, Print)	150	mare?	brive	Balto.	md.	21237
	Sta Regist	ate rar	31. Date filed (Month Day, Year) SFP 2.5 200	32. Registrar's Sign	gnature	Courte	,			7		/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

All Robins Are Legible.

State of Maryland, Department of Health and Mental Hygiene

All Robins Are Legible.

State of Maryland, Department of Health and Mental Hygiene

All Robins Are Legible.

State of Maryland, Department of Health and Mental Hygiene

All Copies Are Legible.

Reg. No. 2006 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day SEPTEMBER ZI, 2006 **Physician** В. 0745 M Martha Young /Medical Center 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Sand Brocke Grove Kehabilitation and Nursing Spring 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Months 91 Vrs Director 579-14-8812 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or Itema 23s or 28s-f shovent, the Medical Exeminer must be notified at Maryland Sandy Spring Montgomery 1 Yes 2X No Director 0e, Street and Number 18201, Stade School, Road 10102, Cedar, Knoll L 10f. Zio Code 20860 10g. Citizen of What Country? United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify þ 3 ☑ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maideg Surname, Washburn 17. Father's Name (First, Middle, Last) Be Mental and Mental Henry Brawner Eugenia Julia ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 Is any injury or other tra once. 10102 Cedar Knoll Lane, Richmond, Virginia 23233 Martha L. Fretwell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium 23, 2006 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Tumphrey Funeral Home . 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. 75 Bethesda, Maryland 20814-3501 Detro P. Chaplan M00092 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADVANCED SENILE DELIENTIA Physician YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) 9□ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ been significant 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the linector, page 2 s autopsy performed 1 ☐ Yes 2X No 1 Yes 2□ No director, 25. Was case referred to medical Be 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🔀 No this After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. ATTENDING PHYSICIAN 042046 30. Name and odress of person who completed cause of death (Item 23a) (Type, Print)

GRACE BROKE HUFFMAN, M.D. 18100 SLADE SCHOOLROAD SANDY SPRINT 31. Date filed (Month, Day, Year) SEP 2 5 2006 32. Registrar's Signature State Registrar

			For State Registrar	State of M	Iarylan	d / Depa <i>Cer</i>	artme <i>rtifica</i>	nt of Health te of Deatl	and M h	lental Hy	giene Reg. No	200	6	30342	2
	Physici		1. Decedent's Name (First, Middle, La Soraya	st) AGH.	AMOLL	A				2. Date of De Month Sept.	Da	у 006		Time of Death 0:55 P M	
	/Medic Examin		4a. Facility Name (If not institution, give 7009 Winslow St.	re street and number	-)			Town, or Location	of Death			County of De			
	uneral irector		105-62-2733	Sex 7. A 1 □ M 2√2 F	ge (In yrs. 53	last birthday) Yrs.	If Und Month:		Min.	8. Date of Bir (Month, Da May 17	th iy, Year) , 19	9. B	irthplace Country) an	(State or Foreign	
Maryland	fahow	lor	Usual Residence of Decedent  10a. State 10b. County MD Montg	omery	10c. Cit	y, Town or Lo Bethe							1	nside City Limits	
with the	3a or 28a	i Director	10e. Street and Number 7009 Winslow St	•			10f. Z	ip Code 20817			10g. Ci	tizen of What (	Country?		
<b>36</b> s atter death	or Items 2	by Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Deceden Armed Forces 1 Yes 2 G	i? INo X	1	_	edent of Hispanic Cocify Cuban, Mexic		ecify Yes or No Rican, etc.)	)-	14. Race - An Black, Wh Specify:			_
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland	no Mental Tygene. Transked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed b	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)			(Give	kind of v DO NDT	ual Occupation ork done during mo use retired)	ost of work	ing	16b. K	(ind of Busines			
e .	nial riggion ed other th c event, the	Be	17. Father's Name (First, Middle, Las. Hayim Cohan			Sale	2 <b>s</b>	18. Mot	her's Name	e (First, Middle		n Surname)	Sak	cs	
Maryland	In and Me I7 is mark trsumati	2	19a. Informant's Name/Relationship Djamchid Aghamoll		e			ss (Street and Nums					, Zip Cod	(e)	
Baltimore,	ont of riesal r: if item 2 y or other		20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci		_   0	Place of Dispo cemetery, cren	natory of	ame of other place) al Garden		.10,20		ocation - City o	or Town,	State	
Baltir permit. P	Department of Health and Menta Important: If Itam 27 is marked eny injury or other traumatic evance.		21. Signature of Fundral Service Lice			22	2. Name	and Address of Fac arroll St	ality Tor	-	у Н	ebrew I	uner	al Home	
	ysician		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	ed the deat line.	h. Do not ent		ode of dying, such a				, = = = =	App Inte Ons	proximate erval Between set and Death months	
	ledical aminer		resulting in death)	Due to (or a										MOILLIS	
8760, sate be executed	physiclan and the burial-transit	dical Examiner	Sequentially list conditions, I any, leading to initial educate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a											
I Records, P.O. Box 68760, The law requires that the death certificate be executed	ttending plor use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ဩ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3	]Ectopic ] Other (	pregnancy specify)				23d. Date of o Month	lelivery Day	Year	
rds, P.	n signed by the a lid be detached t	ě	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderiying	cause given in Par	t I.			use contribute	to the ca Probably		
Records, The law requires t	r this certiticete has been ral director, page 2 should	Completed								24a. Was auto perfe 1  Yes	psy ormed?	death	autopsy fo comple	findings available tion of cause of No	
/ita	ertitic actor,	Be	25. Was case referred to medical examiner?	(terrely de					ice of Deat	h (Check only	one)				
Division of Vital or Attending Physicien: 1	th. : Atter this c s tuneral din	ition: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpa  28a. Oate of Ir (Month, L		28b. Time o Injury		28c. Injury at Work?		me 5 Res 28d. Describe			oecify)		-
Divisi	within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of I	njury - At h etc. <i>(Speci</i>	ome, farm, sti fy)	reet, fact	ory, office		28f. Location ( City or To			Rural Ro	ute Number,	-
ie Hospii	n 24 hours a	Medical (		hysician: To the be miner: On the basis and manner	of examina										
To the		Ř	29b Signature and tyle of certifier	le los 1	17100	1	2	9c. License numbe				ate signed (Mo			
<i>A</i>			30. Name and address of person who Cheryl Aylesw	_					#400	. Wheat	on.	MD 20	902		
- 1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 1 1 2	32 Regis						,					

			For State Registrar	State of Marylar	•	artment of rtificate of				giene leg. No 2001	6 30343
4	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Dea Month		3. Time of Death
	/Medic			ood		T			Septemb	er 12 200	
	Examin	er	4a. Facility Name (If not institution, give str St. Mary's Nursing			4b. City, Town, Leonard		of Death		4c. County of De	
. 20	Time rel	6	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	r If Under		8. Date of Birth	) 9 F	Birthplace (State or Foreign
-	Funeral Director			1 2□XF 90	Yrs.	Months Days	Hours	Min.	(Month, Day Oct. 6	, Year)	Country) Shington, DC
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	vection					10d. Inside City Limits
	ehov e e e e	ō			ty, Town of Lo		1.				1 ☐ Yes 2 🛣No
	28a-1	Director	Maryland St. Mary	7 S		Leonat	ratown		1	10g. Citizen of What	Country?
	3a or	ie D	40365 Rosebank Lar	ie		20	0650			United St	ates
	death	Funeral	11. Marital Status	. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cul		gin? (Spe	city Yes or No-		merican Indian,
9	or It	y Fu	1 ☐ Never Married 2 ☐ Married	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No				Specify: V	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow he Midfell Exercities must be motified at	d by	3 X Widowed 4 □ Divorced  15. Decedent's Educa		162 Doco	dent's Usual Docu	estics			16b. Kind of Busine	
7	in 72 n "nai	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	durina mos	t of workii	ng	TOD. KING OF BUSINE	samoustry
2121	d with giane.	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	]	Teacher				Educ	cation
	be filed ital Hygid od other avent.	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,	Maiden Sumame)	
<u>ya</u>	should to	인	Nicholas Miles						lmina Vo		
Maryland	12 sh h and 7 ls m raum		19a, Informant's Name/Relationship (Type	Value of the	-1					r, City or Town, State	OCCUSERAN
_	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic avent, the Medical Examiner must be notified at anotes.		Linda K. Himmelhebe	20b. I	Place of Dispo	sition (Name of		ane,	Drayder Date	1. Marylar 20c. Location - City	1d 20630 or Town, State
Baltimore,	Pages nent of Int: If Its iry or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Read 1 ☐ Burial 2 🛣 Cremation 3 ☐ Read 2 ☐ Donation 5 ☐ Other (Specify)	noval from State		natory or other pla	' 1	012.	2006	Thom lotte	IIa 11 MD
三	permit. F Departme Importan any njur		21. Signature of Funeral Service Licensee		22	2. Name and Addr	ess of Facili	y Brii	-2000 ( nsfield	Charlotte Funeral H	Home. P.A.
Ö	Depa Impo		Kyle S. Simons	M0120							D 20650-0279
4	×		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the dea	th. Do not ent	er the mode of dy	ing, such as	cardiac o	r respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	REA	aina	toru !	all	ns	١		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	uence of):	1/1	AT	7	7		11000
9	Lxammer	<u>.</u>	Sequentially list conditions, if any, leading to impreciate	Cong	Esliv	<u>Σ</u> / 1 ε α	12/ t	ail	we		mo.
	ted nsit	nlne	Cause (Disease or injury		Dence on.	, -	1	411	<del>-</del>		an
,	execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):	myon	A	T			11) -
8760,	ate be executed hysician and the burial-transit	cail	d.	0.20	masi	1 47)	LEM	11	12		425
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edi	IE EENALE.				-1	, –			4
Вох	eath certific attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	<ul> <li>If yes, outcome of pregn</li> <li>1 ☐ Live birth 2 ☐ Feta</li> </ul>		J ∃Ectopic pregnan	су			23d. Date of o	delivery Day Year
O.	the all	Physician/M	1 ☐ Yes 2  No 9 ☐ Unknown	4☐Pregnant at time of o	death 5	Other (specify)				WORTH	Day ! oa!
Ω.	res that the de signed by the a be detached t		Part II. Other significant conditions conti	ibuting to death but not res	sulting in the u	nderlying cause g	iven in Part I		23e. Did to	bacco use contribute	to the cause of death?
Records,	uires sign lid be	d by							1 🗆 Y	es 2 No 3	Probably 4 Unknown
COL	w requir	Completed							24a. Was a		autopsy findings available
	The lav te has age 2	dmo							autops perfor	med? prior to death	to completion of cause of
Vital		Bec	25. Was case referred to medical		112		26. Place	of Death	Check only or		63 2010
	hysic his ce I direc	To	examiner? 1 ☐ Yes 2 No		ER/Outpatier	nt 3 DOA	ther: 4 🚳 Nu	ursing Hor	me 5 Resid	ence 6 Other (S	pecify)
Division of	ing P	:uo	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W			28d. Describe h	ow injury occurred	
isio	Attending Physicien: r death. sctor: After this certific by the funeral director,	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm st		Yes 2		28f Location /S	treet and Number or	Rural Route Number,
<u>≥</u>	Dirte in	Certification:	4 Homicide determined	building, etc. (Speci	fy)	cot, ractory, onice	,		City or Tow		riara riobio riarribor,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1   Certifying Physic 2  Medical Examine	cian: To the best of my known: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date ar opinion, dea	nd place, a	and due to the c	ause(s) and manner late and place, and c	as stated. lue to the cause(s)
	within To the compli	Me	29b. Signature and title of certifier	$\Lambda \Lambda I$	.11	29c. Licer	nse number	15 11	2	29d. Date signed (Mo	onth, Day, Year)
			Vama	H. Jarlow	EM	) D	06	41	7	9-12-	06
			30. Name and address of person who com	pleted dayse of death (Ite	m 23a) (Type,	Print)					
				I.D. 24035 7	Three N	otch Roa	d, Ho	11ywc	od, Mar	yland 206	36
1	Sta Registi		31. Date filed (Month, Dely, Year) SEP 1 3 2	32. Resistrar's Sign	ature A	fred					

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan	•	artment of I			giene Reg. No. 200	16 30344
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death
	Physicia		CLAUDE R.	BYNAKER				Month SEPTEMB	ER 8 200	
	/Medio Examin		4a. Facility Name (If not institution, give st			4b. City, Town,	or Location of Dea		4c. County of D	
	LAdiiiii	Ç.	Shady Grove Adven	tist Hospital		Rockv:	ille		Montg	omery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year			) 9. (Year)	Birthplace (State or Foreign Country)
	Director		578-34-8873 <sup>178</sup>	M 2□F 77	Yrs.	Months Days	Hours Mir	April 5		Maryland
	D .	Ì	Usual Residence of Decedent	10. 65	· r	4!				10d. Inside City Limits
	shov	_	10a. State 10b. County		y, Town or Lo otomac	cation				1 Yes 2 No
	Bs-f	Director	Md. Montgom	ery	Comac	T			40-02	
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28s-f show the Medical Exeminar must be notitied at	늅	10e. Street and Number 10501 Boswell Lan	е		10f. Zip Code	20854		10g. Citizen of What	
	s 23	Funerai		2. Was Decedent Ever in U.	S 12 1	Mac Decedent of	Hispanic Origin? (	Specify Yes or No-		States mencan Indian.
	ltem Item	Ë	11. Marital Status  1 □ Never Married 2 ☑ Married	Amed Forces?		f Yes, specify Cut	an, Mexican, Pue	into Rican, etc.)		/hite, etc.
8	Ir. or	Þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 195		1 ☐ Yes 2 ☑-No	Specify:		Specify:	White
21215-0036	2 hou	ted	15. Decedent's Educ	ation	16a, Dece	dent's Usual Occu	pation		16b. Kind of Busine	ess/Industry
75	hin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire		orking		
7	giene giene fr	Completed	8	0	Aut	to Techni	lcian		Autom	otive
힏	al Hy al Hy doth	Be (	17. Father's Name (First, Middle, Last)					ame (First, Middle,		
<u>Ja</u>	Ment Ment mrke attre	၉	Phillip Henley	Bynaker					Calhoon	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importants if item 27 is marked other than "neturel; or items 23a or 28s-1 show many injury or other traumatic event, it a Medical Examinar must be notified at an ance.		19a. tnformant's Name/Relationship <i>(Typ</i> Patsy C. Bynaker		4	-		Rural Route Numbe Potomac,	n, City or Town, Stat Md. 208	
ē,	s 1 ar		20a. Method of Disposition	٠ ١ ٠	lace of Dispo	sition (Name of matory or other pla	ica)	Date	20c. Location - City	or Town, State
Baltimore,	Page In: I		1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	ille Cem		14/06	Laytonsv	ille, Md.
ati	permit. Departminente		21. Signature of Funeral Service License	9 0 0	22	2. Name and Addr	ess of Facility	er Funera	1 Home	
00	80 E 5 8		Murief N	· Parke					sville, M	d. 20882
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the deatle cause on pach line.	h. Do not ent	er the mode of dy	ing, such as cardi	ac or respiratory ari	rest,	Approximate Interval 8etween
1	Physician		Immediate Cause (Final disease or condition	11100	Can	PC				Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):					
	Examiner		Sequentially list conditions, b.							
	p iii	Examiner	cause. Enter Underlying	Dualto (or as a nonseq	uence of):					
	and I-tran	хаш	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq	neuce of):					=
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit			200 (0 (0) 23 2 00.1304	usitos 51).					
87	physis the	dicai	d.							
9 X	eath certifii attending p for use as	Physician/Me	IF FEMALE: 23	3c. If yes, outcome of pregna	incy				23d. Date of	delivery
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnand Other (specify)	у		Month	Day Year
P.O.	that the de ed by the detached	ysi	1 ∐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
s, P	requires that the veen signed by th hould be detache	by P	Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did to	pacco use contribut	te to the cause of death?
rds	tw requires that s been signed I t should be det	D D						_ 1₫Y	res 2 □ No 3 □	Probably 4 Unknown
8	s bee	Completed						24a. Was		autopsy findings available
æ	The law sete has b page 2 s	E O						autop perfor	rmed2 deat	to completion of cause of h? Yes 2 No
ta		ا مه ا	25. Was case referred to medical				26. Place of D	eath (Check only or		165 20140
$\leq$	Physicien: this certific	To B	examiner?	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA O	hor		dence 6 Other (s	Specify)
0		n:	27. Man or of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju			now injury occurred	· · · · · · · · · · · · · · · · · · ·
<u>ō</u>	Attending r death.	atio	1 Natural 5 Pending 2 Accident investigation	(	in gory		]Yes 2□No			
Division of Vital Record	P it is	ertification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	Hospital	O		ician: To the best of my kno er: On the basis of examina						
	To the Hos within 24 h To the Fur completely	ledicai	one)	and manner stated.	orranu/or in					
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	( ) (		29c. Licer	se number	>	29d. Date signed (M	
	lett		, - / ~ /	John.		D.	41140	>		er 8, 2006
			30. Name and address of person who con	10.		Print) A	18. 6	izithesbu	a MJ	
	**		31. Date filed (Month, Day, Year)	32 Registrar's Signa	1	A a	, <u> </u>	11/03/00	13 10	
10	Sta Regist		SEP 1 1 20		5 60	are				

		1 - For State Registrar	State of Marylar				lealth a Death	nd Mer	ntal Hy	/giene ,	2006	30	345
		1. Decedent's Name (First, Middle, Last)		-				2.	Date of D Month	eath Day	Voor	3. Time o	Death
Physicia /Medic		Walter Leo Bie	eberly					s		iber 8	, 2006	7:45	рм
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	r Location of	Death		4c. C	ounty of Death		
		Suburban Hospital	L			E	3ethes	da			Mor	tgome	сy
Funeral Director		5. Social Security Number 6. Sex 514-05-5324	7. Age (In yrs. 87	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	Date of B (Month, D	irth la <i>y, Year)</i> 6 <b>,</b> 191	Cou	place (State intry) nsas	or Foreign
P .		Usual Residence of Decedent	100 6	. T								104 (1-14- 0	the distant
arylar ehov	_	10a. State 10b. County	10c. C1	ty, Town or Lo	cation							10d. Inside C	2⊠No
86-f	Director	Maryland Montgomer	су	Silver						45 511	11111 12		
with th		10e. Street and Number			10f. Zip					10g. Citize	en of What Cou	intry?	
e 23	rai	10603 Bucknell Di	CIVE 2. Was Decedent Ever in U	10 10 1	Man Dago		20902	in? /Specifi	v Voc or N	10. 14	USA I. Race - Amer	ican Indian	
Larl yidilid X 1 X 1 X 100000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show aumatic event, tra Medical Evanta or must be redified at	by Funerai	11. Marital Status  1 Never Married 2 x Married  3 Widowed 4 Divorced	Amed Forces?  N☐ Yes 2 ☐ No If Yes, Give 1941 — Year or Dates:	.46	was Dece if Yes, spe 1 ☐ Yes		lispanic Orig an, Mexican, Specify:	Puerto Ric	an. etc.)		Black, White Specily.hite	, etc.	
72 hours natural; dicul Exa		15. Decedent's Educ	cation	16a, Dece	dent's Usu	al Occup	ation			16b. Kind	d of Business/l	ndustry	
within 72 ene. then "net	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	DO NOT u	se retired	during most	or working		U.S.	Depart	ment o	of
d wit	PO		4	Admi	nistr	ator	<u>:</u>			Agri	culture	9	
e filed al Hygie other vent, tr	Bec	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	irst, Middl	e. Maiden S	iumame)		
arylant	2	Alois Bieberly					Marie	Ther	esa E	Budig			
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event		19a. Informant's Name/Relationship (Typ			-						Town, State, Z		
end 27 in 27 in er tra		Betty C. Bieberly					ll Dri	ve, S	ilver	Spri	ng, MD	20902	
Pages 1 ei nent of Hee int: If Item iry or othe		20a. Method of Disposition  1 ☐ Burial 25☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispondence	natory or o	other plac	.   13	Date Sept. 2006	11	1	ation - City or 1		inia
balltimore, inaryilar permit. Pages 1 end 2 should by Department of Heelth and Menta important: If them 27 is marked any Injury or other traumatic enonge.		21. Signature of Funeral Service License  Ken Skile	е	₽ <del>2</del> 50	anci O Uni	d Addre	stoffill sity B	ns Fu	neral	Home			
T.	ii l	23a. Pari 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	th. Do not ent	er the mod	de of dyin	ng, such as c	cardiac or re	espiratory	arrest,		Approxima Interval Be Onset and	tween Death
Physician /Medical		disease or condition resulting in death)	Lung Cancer  Due to (or as a consec	quence of):								2 Mon	cns
Examiner													
	Jer	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	uence of):									
cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events											
O, exec en ar rial-tr	EX	resulting in death) Last	Due to (or as a consec	quence of):									
ate be e	dicai	<b>U</b> d											
og rtifica ng ph as th	Aedi	IE EEMALE.								1			
BOX Of Boath Certific attending post of for use as	Physician/Me	236. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic p	regnancy	,			23	d. Date of deli	-	
o dea he att	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of o		Other (sp						Month	Day	Year
that the de detached to detached	Phy	9 Unknown											
	Ď	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	ause giv	en in Part I.			Yes 2	e contribute to No 3 ☐ Pro	the cause of bably 4	
UNISION OT VITAL MECOLOS, or Attending Physician: The law requires the death.  Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	Completed								24a. Wa aut	s an opsy formed?	24b. Were aut prior to c death?	opsy findings ompletion of	available cause of
									1 ☐ Yes	25 No	1 ☐ Yes	2□ No	
VIII iiciar certif recto	Be	25. Was case referred to medical examiner?	ospital:		_	Oth	or	of Death (C					
OI VITA Physician: r this certific	2	1 ☐ Yes 2 € No  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		JA ]	4 🗀 1401			sidence 6 how injury	Other (Spec	ify)	
Sing Sing After funer	ion	1√2Natural 5 ☐ Pending	(Month, Day Year)	Injury	м .	28c. Injur Wor	k? Yes 2 □ N		J. Describe	i now inquity	Occumen		
Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm et					Location	(Street and	Number or Ru	ra I Route Mur	nher
tal or A safter all Directed in by	Certification:	4 Homicide determined	building, etc. (Speci	fy)	eer, ractor	y, ornee		251	City or To	own, State)	reamber or rea	ar riodie ival	11267,
DIVISION OT VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edicai		nician: To the best of my knier: On the basis of examinand manner stated.										s)
To th withir To th	Me	29b. Signature and title of certifier	20 (	)	29	c. Licens	e number			29d. Date	signed (Month	Day, Year)	
		) que	- Jus				-00-			Se	ptember	8, 2	006
10+1		30. Name and address of person who co	•			-	#400	Pos!-		MD	20052		
-		A Rajvanshi, M.D					#409,	- KOCK	· ^ T T T 6	=, MD	20002		
Sta Registr		31. Date filed (Month, Day, Year) <b>SEP 11</b> 20	32 Registrar's Sign	ature A	Order)	)							

90.8.6

1 tr

WALTER

BIEBERLY

			For State	State of Maryla	and / Departi	ment of H	lealth and M			6 3034
			Registrar		Certif	icate of	Death		Reg. No.	
	Physici /Medio		1. Decedent's Name (First, Middle, La	A-Baca				2. Date of Dea Month Septem	ber 09 200	6 1540 M
	Examin	er	4a. Facility Name (If not institution, giv				Location of Death		8altin	
			Tohns Hopkins 5. Social Security Number 6. S			Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Funeral Director			1⊠M 2□F 82		onths Days	Hours Min.	May 8,	r, Year) C	rthplace (State or Foreign ountry)
	land M		10a. State 10b. County	10c.	City, Town or Location	on				10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic avent, the Medical Examinar investive inclined at	Completed by Funeral Director	Virginia Fairfax  10e. Street and Number	<u> </u>	Burke	Of. Zip Code			10g. Citizen of What C	1 ☐ Yes 2 No ountry?
	3a o	0	9642 Burke Lake F	Road, Apt, #3	06	22015		1	United Sta	tes
	death	Jer	11. Marital Status	12. Was Decedent Ever in Armed Forces?			ispanic Origin? (Sp an, Mexican, Puerto			erican Indian,
9	after or its	Ē	1 Never Married 2 Married	1 X Yes 2 □ No		s, speciny cuba Yes 2⊠ No	Specify:	rican, etc.)		ite, etc.
21215-0036	ours,	å b	3 ₩ Widowed 4 Divorced	Year or Date Unkn	own	Tes ZIAINO	<i>Specify:</i>		Specify: W	hite
5-0	72 h	etec	15. Decedent's Education (Specify only highest gradual)	ducation	16a. Decedent	's Usual Occup	ation during most of work t)	ing	16b. Kind of Business	s/Industry
21	within ene. then	ф	Elementary/Secondary (0-12)	College (1-4or 5+)	1					
	ygier ygier har th	S		2	Owner/	Operate			Real Est	ate
P	tai H doth doth	Be	17. Father's Name (First, Middle, Last,	,	T.			e (First, Middle,	Maiden Surname)	. 1
yla	ould Men warke	္	Angelos		Bacas		Doula			rakos
Maryland	i 2 should be filed within 7 n and Mental Hygiene. I is marked othar than "r raumatic avent, the Med		19a. Informant's Name/Relationship (						r, City or Town, State,	
	os f and of Health itam 27		Diane B. Hoffman						burg, VA 2	
9	ges i if ita or ot		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □	Juanioval Iloni State	<ul> <li>Place of Disposition</li> <li>cemetery, cremato</li> </ul>		1		20c. Location - City o	r Iown, State
Ë	men tant: jury		4 □ Donation 5 □ Other (Specif		airfax Me			_	Fairfax, V	irginia
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licentary	MO09			ss of Facility emorial F dock Koad		Home ax, VA 220	32
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not enter th	ne mode of dyin	g, such as cardiac	or respiratory ari	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Brain	hernia	tion				Onset and Death
7	/Medical		resulting in death)	Due to (or as a cons		(1.0.)				
	Examiner		Out and the first and the second	. Increase	e intra	cranic	al pres	sure		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons						
	te be executed ysician and e burial-transit	Examiner	that initiated events	· Massivi	e injur	ction	in ri	sht b	rain	
ó	an ar		resulting in death) Last	Due to (or as a cons	sequence of):			N	emisphere	
1760	ite be iysici ne bu	icai	(	_ d						
89	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medi	IEEE III							
Вох	th ce endir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F		opic pregnancy			23d. Date of de	
<u> </u>	dea death	Sicie	in the past 12 months? 1  Yes 2 No	4☐Pregnant at time of		ner (specify)			Month	Day Year
P.O.	by the	ř.	9 Unknown	9EI ONKNOWN				1		
Ś	es tha	by F	Part II. Other significant conditions of	contributing to death but not	resulting in the under	tying cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
p	en si ould	ed	<del></del>					1 U Y	es 2□No 3□P	robably A Dinknown
သို့	aw reas be	plet						24a. Was a		utopsy findings available
æ	The ste his	E O						perfor		completion of cause of s 2520No
ita	ian: rtifice stor. p	BeC	25. Was case referred to medical				26. Place of Deatl			-7
<b>&gt;</b>	nysic lis ce direc	ToE	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatient 3	3□ DOA Oth	er: 4 🗆 Nursing Ho	me 5 Resid	ence 6 Other (Spe	ecify)
Division of Vital Records,	ng Ph terth nerat		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injun Wor	y at	28d. Describe h	ow injury occurred	
<u>0</u>	ath. or: Af	atic	2 Accident investigation	n			Yes 2 □ No			
<u>≥</u>	r Attu er de recto by th	ti ti	3 ☐ Suicide 6 ☐ Could not b		t home, farm, street,	factory, office		28f. Location (S City or Tow	treet and Number or F	tural Route Number,
	is aft ai Di ed in	Cer		3, 515 (5,					., 5.215)	
	To the Hospital or Attanding Physician: The law within 24 hours after death.  Yo the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification;	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1	hysician: To the best of my liminer: On the basis of exam and manner stated.	knowledge, death occinination and/or investi	curred at the tin igation, in my o	ne, date and place, pinion, death occurr	and due to the c	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	orthin orthin		29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon	
	11		Ami 10. 17	lankadi M	$\mathcal{O}$	RES	000	9	sentember	09.20NC
4	T		30 Name and address of person who	completed cause of death (	Item 23a) (Tugo Brin	.,				1,1200
(	3)		30. Name and address of person who Johns Hopkins Bay. 31. Date filed (Month, Day, Year)	ies Medical Ce	whee 494	O East	tern Aven	ue Balt	imove MD?	21224
	Sta Registr	ue	SEP 1 1 2	2006 Species Signature	gnature Appea					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Edward Burns Jerome September 17,2006 7:30AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. Min. October 23, 1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ₩ 2 □ F 203-05-0173 91 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28e-f show r then "natural", or itema 23a or 28e-f shovine Medical Examiner must be notified at 1XYes 2 □ No Directo Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Kent Ave. 20646 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Chief Financial Officer Communications 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny lighty or other traumatic event sons. Michael Joseph Burns Mary Ellen Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane David/Daughter 700 Kent Ave. La Plata,MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State St. Mary's Cemetery9/23/06 Wilkes-Barre, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup>AREHART ECHOLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata.MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Physician /Medical Due to (or as a consequence of):

Congestive Heart Failure **Examiner** Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Cardiomyopathy or Attending Physician: The law requires that the death certificate be executed year ding physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Coronary Arterty Disease years Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? C.O.P.D. Pneumonia 1 Yes 2 No 3 Probably 4 X Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 ⚠ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 Yes 2 No 2 Accident 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29a. Certifier Medical 29b. Signature and time of certifier 29d. Date signed (Month, Day, Year) c. License number D06419 ause of death (Item 23a) (Type, Print) 24035 Three Notch Rd. Hollywood, MD 20636 /D Jarboe, M James 31. Date filed (Man State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 30348 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 19, 2006 3:33 PM M **Physician** Betty Irene Brunner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizens Nursing & Rehabilitation Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 26, Year 929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 200F Mary Tand 77 218-24-8824 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or Iteme 23a or 28e-f eho: treumatic event, the Modical Examinar must be notified at 1 Yes 2 No Frederick Frederick Maryland Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21701 U.S.A. 9438 Gas House Pike death Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 [] Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after in and of eatility and Mental Hygiene. and It I tem 27 is marked other than "naturel; or Item in the treumatic event, the Medical Examinatiny or other treumatic event, the Medical Examinatiny. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eye Glasses/Manufacturing Factory Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary E. Nusbaum John William Cromwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9438 Gas House Pike, Frederick, MD 21701 James W. Brunner, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Depertment of H
Important: If Ite
any Injury or ot
once. 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Sept. 25, 2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License <sup>22. Name and Address of Facility</sup>
Keeney and Basford PA Funeral Home
106 East Church St., Frederick, MD 21701 Kichard MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknows significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Othe 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes 1 Inpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient this 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 2 No death 1 TYes 2 Accident I Director; d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to Funerel Dietely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. Medicai 29a. Certifier efor investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) September 20, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	ırtmen <i>tificati</i>	t of H e of L	lealth ai D <i>eath</i>	nd M		giene Reg. No.	200	)6	30	349
			Decedent's Name (First, Middle, Las	1)							2. Date of De		Υ.	ear ;	3. Time of	Death
	Physici /Medio		Sarita Bragg I	Baker							Septem	ber 1	18, 2	00614	420	рм
	Examir		4a. Facility Name (If not institution, give				•		Location of				County of			
			Harford Memoria  5. Social Security Number 6. Se			ast birthday)	Hav If Under		le Gra		9 Date of Bio		Harfo		o (Stato	or Foreign
	Funeral Director			M 2√F	95	Yrs.	Months	Days	Hours	Min.	B. Date of Bir Month, Da July 2	Year)	911	Mary		or Foreign
	70		Usual Residence of Decedent											<del>_</del> _		
	anylan show	_	10a. State 10b. County			, Town or Lo	cation							10d.	Inside C	ity Limits 2 \Begin{array}{c}\text{No}
	death with the Maryland ms 23a or 28a-f show fmust be nettired at	Director	MD Harfor	rd	Abe	erdeen	104.7	0.1				10 0'''			1122	2   140
	with t		10e. Street and Number 45 Smith Ave.				10f. Zip	001				•	en of Wha	it Country	"	
	leath ns 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S		Vas Deced	dent of H	ispanic Origi	in? (Spe	cify Yes or No		4. Race -	American	Indian,	
- (	after of the remaining the rem	핊	1 ☐ Never Married 🌠 Married	Armed Forces? 1 ☐ Yes 2 ☑ 1	No	li li	Yes, spec	offy Cuba	ın, Mexican,	Puerto F	Rican, etc.)			White, etc		
7 8	ours ours	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			□ Yes	281 No	Specify:				Specify:	White	<del></del>	
0	72 h	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced	lent's Usua kind of wor	d Occup	ation during most of	of workir	g	16b. Kin	d of Busin	ess/indus	stry	
2	withir then	d mc	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Sales	)O 14O 1 B	se remed	,			Clot	hing			
7	filed Hygi other	Be	17. Father's Name (First, Middle, Last)	0					18. Mother	's Name	(First, Middle					
	Viain uld be Menta rked tic av	To B	Louis Goodman						The	resa	Treum	an				
9	2 sho and h is ma	Ċ	19a. Informant's Name/Relationship (7				_				Route Number				ode)	
0	and and man man man man man man man man man man		Abraham M. Baker	(Spouse)							n, Mar			001	-	
20/8	IOTE		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐			ace of Dispos metery, cren					ate		ation - Cit			. J
1	DESITIMOTE, MATYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant, the Madical Examinational Sea natified at once.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service License		нері	rew Fr		_					umore	, Mai	сутаг	Ю
0	Dem Depe Impo		Mara C.	Bell	ma		arrin berde	ig-Ca en,	rgo F Maryl	uner and	al Hom 21001	e, P -3399	) <sup>A</sup> .			
			23e Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each li	ne.					ardiac o	respiratory a	rrest,		In	pproximaterval Bet inset and	meen
	Physician		Immediate Cause (Final disease or condition resulting in death)	. STA1	2Un	EPIL	SPN	လေ S	•						tho	
	/Medical Examiner		Toolang in doutin,	Due to (or as	a consequ	ence of);										
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	unes of):										
	cuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												
ç	6 / 6U, ate be executed hysician and the burial-transi		resulting in death) Last	Due to (or as	a consequ	ence of):										
1	od / ou, icate be executed physician and s the burial-transit	dlcal		d										-		
	j je ga ëi	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv							0.4 D-4-	4 delisees		
ć	T.C. BOX of that the death certification of by the attending of detached for use as	clan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pr					2	3d. Date o Month		ау	Year
9	nat the d d by the etached	hysi	1 Yes 2 No 9 Unknown	9□Unknown												
	S, T	Completed by Physician/Me	Part II. Other significant conditions co	ontributing to death b	ut not resu	lting in the un	nderlying c	ause giv	en in Part I.		23e. Did t	obacco us	se contribu	ite to the	cause of	death?
T.	OT VICAL MECONDS, Physician: The law requires to this certificate has been signed that director, page 2 should be to a signed to the state of the st	ted								_	1 🗆 '	Yes 2□	]No 3[	☐ Probab	ly 4 💢	Unknown
8	Hecc e law r has be ge 2 sh	ple									24a. Was	osv	24b. Wei	re autopsy	y findings letion of d	available ause of
Q -	r VICAI KEO ysician: The la is certificate has director, page 2	Con									perfo	rmed? 2 No	dea	th? Yes 2[		
E	OT VICAL P Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🗸				Oth	or		(Check only o					
SAR	Phys r this ral dir	2	1 ☐ Yes 2 No  27. Manner of Death	1 Inpatie		R/Outpatien 28b. Time of			4 🗀 (40)		ne 5 Resi			(Specify)		
S	Attanding In death.  Actor: Alter by the funer	tlon	1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	м	8c. Injun Worl 1 □	k?` Yes 2 ⊟N		000011001	11011 111,121.9	50041104			
	LIVISION  I or Attanding after death.  Diractor: Attention of the function of	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ury - At hor	me, farm, stre	eet, factory	, office		2	8f. Location (		Number	or Rural A	oute Nun	ıber,
ï	oltal or urs afte eral Dir	Cer														
	DIVISION OF  To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phyone (Check only one) 1 Medical Example 1 Medical Exam	ysician: To the best iner: On the basis of and manner sta	f examinati	ion and/or inv	estigation	at the tin , in my o	ne, date and pinion, death	piace, a n occurre	nd due to the	date and	and mann place, and	er as state I due to th	ed. e cause(s	s)
	To the within 2 To the complet	×	29b. Signature and title of certifier				290	. Licens	e number				signed (A	_		
			10/11/2		•		L	00	562	96		4 -	18	- 20	70 F	>
	67		30. Name and address of person who	completed cause of d	50 1	23a) (Type, I	Print)	IA	VE	140.	IRE de	, C-0	ace	Ma	210	78
	Sta	ate	31. Date filed (Month, Day, Year)	32. Segistr	ar's Signat	uge A	P	. / ! !	, E	/ 17	inc ye		102	-10	$\alpha 10$	10
	Regist		SEP 2 5 20	106	as A	J. A.	BASIL.									

		For State Registrar	State	of Mai	ryland /			nt of H te of L		and Me	ental Hy	giene Reg. No	200	6	30350
4.		1. Decedent's Name (First, Middle, La	st)								2. Date of De	aath			3. Time of Death
Physicia /Medica	_	Richard	d Calve	rt C	rim							nber	13,20		7:30A M
Examine		4a. Facility Name (If not institution, giv		umber)					Location o			40	County of D		
	ilk.	23186 Three Notc 5. Social Security Number 6. S		7 400	(In yrs. last	the implies and to a cit		er 1 Year	ornia    Under:		0. Data of Bi	eth.	St.		
Funeral Director			M 2□F	7. Age	57	Yrs.	Month		Hours	Min.	8. Date of Bi (Month, Di April 2	7, 19	949 Ma	Count Count ryla	ace (State or Foreign ry) and
pu k		Usual Residence of Decedent  10a. State 10b. County			10c. City, T	own or Lo	cation							10	d, Inside City Limits
Aaryla Fehor	ō		1 _											10	1 ☐ Yes 2 🗓 No
28a-	Director	Maryland St. Mary  10e. Street and Number	S		La	liforr		ip Code	-			10a, Ci	tizen of What	Count	
3a or	<u>a</u>	23186 Three Notch Ro	ad.					20619	)				USA		•
death	Funeral	11. Marital Status	12. Was De	Forcas?		13. \	Was Dec	edent of Hi		gin? (Spec	cify Yes or No	o-	14. Race - A		
s after	by Fu	1 Never Married 2 Married	1XXYes	2 □ No Sive	)			2∭ No	Specify:	, 1 00.10 1	iouri, etc.)		Black, W Specify:		
hour	ed b	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's E.	Year or	Dates:	1	6a Decec	lent's Us	ual Occupa	ition			16b K	(ind of Busine	Whit	
nin 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed	f) (1-4or 5+)		(Give	kind of w	rork done d use retired,	luring most	of workin	g	100.11		33/11/0	ustry
giene r th	E	11	College	(1-401 54)		Tow T	ruck	Driver	•			Tow	ing Comp	any	
be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last,	)								(First, Middle				
Man Man Marke	၉	Calvin Samuel Crim	7 0:4								Elizabet				
d 2 st d 2 st th and 17 te n traun		Jacqueline Sue Will:		ond									or Town, State Land 206	. ,	Code)
tem 2		20a. Method of Disposition	15 / 1110	enu	20b. Place	of Dispo	sition /N	ame of	1	Septer			ocation - City		vn, State
Page:		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		n State		and Ve Cemete		other place IS		15, 20		Che.	ltenham,	Mar	vland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licer	nsee /		. 0	22	Name	and Addres	s of Facilit	v					<i>y</i>
40E 8 8		Frichael Kerr	wHas	dine	1						eral Hor wn, Mar		20650		
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on	each line								irrest,			Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	u				V	with	me	tast	a ses				years
Examiner			Due to	o (or as a	consequen	ce of):									
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a	consequen	ce of):									
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												
		resulting in death) Last	Due to	o (or as a	consequen	ce of):									
8 5 5	dical		d											-	
attending	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o										23d. Date of	deliver	v
death death d for 1	Physician/Me	in the past 12 months?	4□Preg	gnant at tir	Fetal death		Ectopic Other (	pregnancy specify)					Month		Day Year
by the detached	,hys	9 Unknown	9□ Unk	nown											
s and a	ò	Part II. Other significant conditions	contributing to	death but	not resultin	g in the ur	nderlying	cause give	n in Part I.				. 1		cause of death?
w requir been si should	eted										1 🗆	Yes 2	No 3□	Proba	bly 4 □Unknown
e law has b	Completed										24a. Was		24b. Were prior t death	to com	sy findings available pletion of cause of
	S	OF Management and the market									1 Yes	2 No		es 2	2000
ysicien: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient	2   FB/	Outpatien	t 3 🗆 0	Othe	-		Check only		6 ☐Other (S	200/6/	
ding Phy After this funeral c		27. Manner of Death	28a. Date	e of Injury	281	b. Time of Injury	. 000	28c. Injury Work	at		3d. Describe			рөспу)	
tending Jeath. tor: After the funer	atio	1 Natural 5 Pending investigatio	n		, , ,		М		es 2□N	No					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not b 4 Homicide determined	288. Plac	ce of Injury ding, etc.	y - At home (Specify)	, farm, stre	eet, facto	ry, office		2	Bf. Location ( City or To			Rural	Route Number,
To the Hospital or Ai within 24 hours after To the Funerel Direc completely filled in by	al Ce	29a. Certifier 18 Certifying Ph	vsician: To th	ne best of	my knowled	dne death	occurre	d at the tim	e date and	d place, ar	nd due to the	causa/s	) and manner	ac cta	ted
Hos 24 hos Eur Hetely	edica	(Check only 2 Medical Examone)	niner: On the	basis of e	xamination	and/or in	estigatio	n, in my op	inion, deat	h occurre	d at the time,	date and	d place, and d	lue to t	the cause(s)
To th To th comp	Σ	29b. Signature and title of certifier	1.	- 1				9c. License					ite signed (Mo		
111	-	I atter	iding	pny	516191	n		Do	0220	82			9/13	12	.006
150		30. Name and address of person who	completed car	use of dea	th (Item 23	a) (Type,	Print)	oaklei	3t.	Tuit	2, [	eone	ardtown	M	070650
Stat	_	31. Date filed (Month, Day, Year)		Registrar'	s Signature		M's								
Registra	r	SEP 1 5 20	06	in	D.	4									

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Benjamin Harrison Clipper

		- For State Certificate of Death Reg. No. 2006 3035
Physicia Medical Exami	111/	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year 1750 hrs
redical Examin	lei	BENJAMIN HARRISON CLIPPER September 6, 2006 1750 hrs  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		14050 BarryVille Road Germantown Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min.
Director		215-20-2915 XM 2 F 79 Yrs. Months Days Hours Min. May 11,1927 Country) MD
ŕ	- }	Usual Residence of Decedent  10a. State
d de se		MD Montgomery Germantown 1 Xes 2 No
Maryland 28a-f show any 1 at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.		14050 Berryville Road 20874 U.S.A.
h with	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, 15. Never Married 2. 32 Married Armed Forces? 16. Was Decedent of Hispanic Origin? (Specify Yes or No- 17. Never Married 2. 32 Married White, etc.
er deat	Fur	1 X Yes 2 No
urs aft tural"	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
5-0036 led within 72 hour Hygiene. I other than "watt	ompleted	Elementary/Secondary (0-12)  College (1-4 or 5+)  during most of working life. DO NOT use retired)
Nedic	g m	12th Lab Technician N.I.H.
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	17. Father's Name (First, Middle, Last)  Harry Clipper  Ruby Washington
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	0 B	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20874
		Harriet W. Clipper (Wife) 14050 Berryville Rd., Germantown, MD
Baltimore, I permit Pages I and Department of Heal Important: If item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, remailed by Place of Disposition (Name of cemetery, remailed by Place) 20c. Location - City or Town, State
Baltimore permit. Pages I Department of F Important: If i		Seneca Cemetery   9/11/06   Germantown, MD
Balti Bermit Departit Imports		1. Signature of Funeral Service Lineace  22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A.  246 N. Washington St., Rockville, MD
Physician	$\triangleleft$	234 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart
/Medical		failure. List haly one cayse on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death.) Last  Due to (or as a consequence of):
cuted ind transit		events resulting in death) Last Due to (or as a consequence of):  d.
an exe	//Medical	UNPENDED AMENDED
760, ficate bo	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the
Box 68 death certif the attending	ciar	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
that the death certificate by the attending detached for use as	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
ords, P.O. w requires that is been signed b		24a. Was an 24b. Were autopsy findings available
COF law rather has be e 2 sho	Completed	autopsy prior to completion of cause of performed? death?
tal Rec cian: The certificate ector, page		25. Was case referred to medical 26 Place of Death (Check only one) 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vita hysician this cer	o Be	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other4 Nursing Home 5 Residence 6 Other. Scene
ding Ph	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ivision or Attend after death Director:	atio	1 V Natural 5 Pending 2 Accident Investigation 1 Yes 2 No
	Certification:	3 Suicide 6 Could not be determined Copyrights Suicide 6 Could not be determined Copyrights Suicide Copyrigh
e Hospit n 24 hour e Funer:		4 Homicide 29a Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.
To the Hospital within 24 hours. To the Funeral completely filled	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
10		Patruci bronica - Pollskins O.C.M.E. September 7, 2006
		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	ate	31. Date filed (Month, Day Year)
Regist		SEP I 1 2008 Pagence Do Pagence Do

sicia	n.	State Registrar  1. Decedent's Name (First, Middle, Last,		Ce	artment of H rtificate of I	Death	2. Date of Death	J. No.	3. Time of Death
dic		Anthony Christop					Septembe	r 7, 2006	6:22 PM
mine	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of Dea	th
ral or		Montgomery         Genera           5. Social Security Number         6. Se           279−68−6522         1√x		s. last birthday) 5 Yrs.	Olr If Under 1 Year Months Days	IEY If Under 24 Hr. Hours Mir		(ear) 9. Bir	gomery thplace (State or Foreign puntry)
		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
once. O	ctor	Maryland Montgome	ry	Olne	·y				1 ☐ Yes 2 🖾 No
	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	-
	Funeral	4672 Weston Place	12. Was Decedent Ever in	118 13		9832	Specify Vec or No.	USA 14. Race - Ame	
	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 25€ No	Specify:	rto Rican, etc.)	Black, Whit	Black
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired			Sb. Kind of Business	
		17. Father's Name (First, Middle, Last)		_	Computer		ame (First, Middle, Ma	Retail	•
	To Be	Lameus Christoph	er, Jr.				ie Ree Rey		
		19a. Informant's Name/Relationship (T) Eva-Mae Herring Mi					Gural Route Number, Ce, Olney,		
,		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, crei	osition (Name of matory or other plac even Cemeter	¦Sept	t. 16,	oc. Location - City or	
		21. Signature of Funeral Service Licens  Ken Skile		F2	Name and Address	Collins	Funeral H	lome Inc.	g, Maryland , MD 20901
		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the dea ne cause on each line.	ath. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory arres	t,	Approximate Interval Between Onset and Death 24 Hours
		resulting in death)	Due to (or as a conse						2 Days
	Ä	Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
	Medicai	IF FEMALE:	0. 1						
	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fer 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
I.	<u>ا</u> ۾	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			o the cause of death?
	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
4	Be	25. Was case referred to medical examiner?	locaital:		100	_	eath (Check only one)		
	<u>۲</u>	1≹ Yes 2 No r		28b. Time o		4   Nursing	Home 5 Residen		city)
	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Injury	M 1 🗆 '	? ′es 2 □ No			
	Certif	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, rarm, str	eet, factory, office		City or Town,	et and Number or Ri State)	urai Houte Number,
	edicai	(Check only one)	ner: On the bast of my kn ner: On the basis of examin and manner stated.	iuwledge, deat nation and/or in	vestigation, in my op	e, date and place inion, death occ	urred at the time, date	se(s) and marmor as e and place, and due	e to the cause(s)
	Ž	29b. Signature and little of gertifier	1000,	/ MC	29c. License	_		Date signed (Mont	
	Ì	30. Name and address of person who co		em 23a) (Type,	Print)	11 / /	IR. OLNE	E CM DEIZ	O D L COR
14	1	CURTIS OLL	440S 1810				1-m P 1 A 12-	11	

### 06-06682

Please Type or Print in Black Indelible Ink

mael Toledo-	-Cas	ro State	ate of Maryland /		ent of	Health			Hygiene		200	36 0	0050
Physic	ian/	Registrar  1 Decedent's Name (First, Middle			_				2. Date of	Reg. No Death		3. Time of De	0353
ledical Exam		Ismael  4a. Facility Name (if not institution	Toledo	Cas	stro	b. City, Tow	n or Loo	ation of Do		Day nber 6,	Year 2006 1c. County of Deat	0700 hrs	
		University Blvd & Arco			"	Wheator		attorior De	eau i		Montgomery	1	
Funera Director		none	6. Sex 7. Age	(In yrs. last birth	nday) Yrs.	If Under 1 Months	_	Under 24 Hours	Hrs. 8. Date o	f Birth(MN	1975 Society (1975) 9. 8ii	thplace (State of State or )	
th the Maryland 23a or 28a-f show any notified at once.	l Director	Usual Residence of Decedent  10a. State MD  10b. County Monto  10e. Street and Number 907 First Sti	gomery	10c. City, Town o	/ill	10f. Zip Co 2	0850	_			itizen of What Cou	10d Inside Ci 1 Yes 2	
rs after death wi ural", or items miner must be	by Funera	45 Divide the Education (Occasion	1 Yes 2 forced If Yes, Give Year or Dates:	X No	If Ye	Yes 2	uban, Me  No sp  cupation (	exican, Pue ecify: Me Give kind	( Specify Yes of erto Rican, etc.)  Exican  of work done		14. Race - Amer White, etc. Specify: Kind of Business/	White	ck,
215-0036 be filed within 72 hou matal Hygiene rked other than "natient, the Medical Exa		Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle,	College (1-4 or 5			et In	stal	ller	retired) ame (First, Midd		Carpet (	Co.	
e, MD 21215-0036  1 and 2 should be filed within 75 Health and Mental Hygene Health and Mental Hygene remain in arked other than re tranumatic event, the Medical	o Be	Manuel Toleo  19a Informant's Name/Relationsh Miriam Selvas	do Lopez	. <b>_</b> 19b	. Mailing	Address (	N	Maria	a Del	Rosa	ario Ca:		
e, MD 2 Fand 2 shou Health and M fitem 27 is n		20a Method of Disposition		20b. Place of	f Disposit	tion (Name o	of cemete	ry, T	Date	20c	City or Town, State Le, Mary Location - City or	Town, State	
Baltimore, MD oernit. Pages I and 2 shu Department of Health and Important: If item 27 is injury or other traumat in item 27 is		1 X Burial 2 Cremation 4 Doctation 5 Other 20 21. Significant of Funeral Section 1	ecify:	La E1	22014	me and Apk	dress of F	AMES	/20/06 LDI FU	NER <i>I</i>	Conala, AL SERV	ICE,P.	Α.
Physician	1	23a. Part I. Enter the disease, or o	complications that caused (	the death. Do not							ver Spr	ing,Md	
/Medica ∹xamine	ш.	failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)										Between Or Deat	nset and
d sir	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	b.  Due to (or as a consect  Due to (or as a consect										
oe executed cician and urial - transi	<u> </u>	UNPENDED	d AMENDED										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death creating the form of the Funeral Director: After this certificate has been signed by the attending physici Tompletely filled in by the funeral director, neae 2 should be detached for use as the burn	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at t	2	$\equiv$	al death er (Specify)		ctopic pre	gnancy	2:	3d. Date of deliver Month	•	'ear
i, P.O. I rires that the signed by the be detached	by Phy	Part II. Other significant condition	ons contributing to death	but not resulting	in the ur	nderlying cau	use given	in Part I.			No 3 Pro		
Division of Vital Records, Is after death as a President Secures. It is after death al Director: After this certificate has been signed in by the funeral director, nage 2 should be ged in by the funeral director, nage 2 should be	Completed								р	utopsy erform <u>ed</u> ?	prior to death?	utopsy findings a completion of ca	ause of
tal Recian: The certificate ector, page	Be Co	25. Was case referred to medical examiner?				26. F	_		eck only one)	es Z	No 1 🗸 Y	es Z	No
f Vita Physici er this c	<u> </u>   2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatier		tpatient		Othe Injury at		rsing Home 5		dence 6 Othe	r: Scene	
on of ending Pl ath or: After he funera	tion:	1 Natural 5 Pend	ing FOUND: Day, Ye	FOUI	ND:	· ·		2 <b>N</b> o			l object collision	on	
Division attropression or Attropression	Certification:	3 Suicide 6 Could	tigation Sep 6, 2008 28e. Place of Injuries (Specify) Loc	ury - At home, fai		t, factory, off	fice buildi	ng, etc.	or Tow	n, State)	and Number or Ru & Arcola Ave.,		
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.			on, in my op	inion, dea	ath occurre		date and p	lace, and due to th	ie cause(s)	
	2	29b. Signature and title of certified	1. King D	20, min	4.		cense nu ).C. <b>M.</b> E				Date signed (Mo		
		36. Name and address of person Theodore M. King, Jr.,			ner	111 <u>Pe</u> nr	street	, Baltim	ore, MD 21	201			
Regi	State istra	31. Date filed (Month, Day, Year)		's Signatur	April	vili)					-	<del></del>	

			For State Registrar	State of N	Marylan	d / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M	lental Hyg	giene2 (	006	30354
	Physici		Decedent's Name (First, Middle, L.  James	ast)		•	Dob	rv			2. Date of Dea Month September		O6 Year	3. Time of Death 3:10 A M
	/Medic Examin	-	4a. Facility Name (If not institution, gr	ve street and number	er)				Location of		P		nty of Death	
4 40	LAdillii		22333 Manos Dr:	ive			Gre	at M	ills			S	aint M	lary's
	Funeral Director				Age (In yrs. 85	last birthday) Yrs.			If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day November	9, 192	Cou	place (State or Foreign ntry) yland
	ehow ed at		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	death with the Maryland ime 23e or 28e-f show Littlest be notified at	Director	Maryland Saint 1	Mary's		Great	Mills					10g. Citizen	of What Cou	1 ☐ Yes 2 ☑ No ntry?
	th with 23a or	۵	22333 Manos Driv	9			20	634				USA		
36	or its	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 17 Yes 2 If Yes, Give Year or Date	es? ⊡`No		Was Deced If Yes, spec	37	spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)	8	lace - Amen lack, White	, etc.
9	"natural",		15. Decedent's I	Education		16a. Dece	dent's Usua	I Docupa	ıtion			16b. Kind o		
1215	within ane. then	Completed	(Specify only highest g Elementary/Secondary (0-12) 12	rade completed) Coltege (1-40	or 5+)	(Give life. Genera	kind of wor DO NOT us	k done d e retired,	luring mos )	t of work	ing	Home		
Maryland 21215-0036	be filed Ital Hygi of other	Be	17. Father's Name (First, Middle, Las			0011011			18. Mothe		e <i>(First, Middl</i> e, Elizabet		ame)	
2	hould Men marke	2	Edward James Dobry 19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a			al Route Numbe		vn, State, Zi	p Code)
Ma	s 1 and 2 should f Health and Mer Item 27 is marks other traumatic		Joseph D. Miesowitz				-				yland 206	-		
Jore,	000-		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3	☐Removal from Sta	110	Place of Dispo cemetery, crea	natory or o	ne of ther place	9)		Date	20c. Locatio		
Baltimore,	permit. Pag Department Importent: I eny injury o		4 Donation 5 Other (Special Service Lice)		Ho]	y Face	Alama an	d Addron	a of Capilit		2000			Maryland O Fenwick St.
	Ä.		23a. Pan1. Enter the disease, or co shock, or heart failure. List one Immediate Cause (Final	y one cause on each	h line.		er the mode	e of dying						Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or	as a conseq Lomyop		Fall	ıre						2 years 5½ Years
100	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·	nary .	uence on: Artery	Dise	seas	e					6 Years
8760,	cate be executed oblysicien and the burial-transit	dical Exa	resulting in death) Last		as a conseq									
P.O. Box 68	ne death certific the ettending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2∐Feta tattime of d	ıl death 3[	□Ectopic pr □ Other (sp						Date of delive Month	very Day Year
	res that the igned by be detact	by Ph	Part II. Other significant conditions  Cerebrovascu	-		sulting in the u	nderlying c	ause give	n in Part I		23e. Did to			the cause of death?
corc	aw requir as been s 2 should	Completed by	Pulmonary Fil			abetes	Mel1	ius			24a. Was	an 24	b. Were aut	opsy findings available
æ	The ta	E	Left Ventric		rtroph	v mode	rate				perfo	med?	death?	22146
ita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Deat	h Check only o	-		
<u>_</u>	nysicien: ns certific i director,	To	1 ☐ Yes 2 1 → Yo	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie			4 🗆 140	ursing Ho	ome 5 Design	ence 6 🗆	Other (Spec	rfy)
Division of Vital Records,	Attending Physicien: r death. sctor: After this certifica by the funeral director.	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	f 2	8c. Injury Work	vat ⟨? Yes 2□	No	28d. Describe h	low injury oc	curred	
Divis	after death, after death, Director: A d in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place of	Injury - At h , etc. (Speci	ome, farm, st	reet, factory	, office			28f. Location (S City or Tox		mber or Rui	ral Route Number,
1	Tothe Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C		Physician: To the beaminer: On the basi and manner	is of examina									
V	To the compl	Me	29b. Signature and title of certified	JADO	mD	>			number /	96		29d. Date sig		
		1	30. Name and address of person what To A D A	o completed cause		п 23a) (Туре, 054	Print)	la,	1000	10	on FED	Col. L.	DNIB	, MP 2061
	Sta	ate	31. Date filed (Month, Day, Year)	2006 32. 69	jistrar's Signa		and)	1		- Lue	77, 110,	11/0		2001

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2006 30355

	Certificate of Death	Reg. No.
Di vivia	Decedent's Name (First, Middle, Last)	2. Date of Deeth Month Day Year 3. Time of Death
Physician /Medical	THELMA VIRGINIA EVANS	September 18 2006 4 PM
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	ation of Death 4c. County of Death
	15 Social Security Number 6 Say 7 Ang //n vrs last highday   If Under 1 Year   If Under 24 Hrs.	no And Fact
Funeral	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director	413-38-8834 10 M 20 P 80 Yrs. 10 M 20 P 80 Yrs. 10 M 20 P 80 P 80 P 80 P 80 P 80 P 80 P 80 P	8/25/1926 Tennessee
/lend	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
the Meryler 28s-f show notified at	MD. Harford Bel Ai	r 1 □ Yes 2 X No
or 284 a not	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
death with the Merylend ms 23a or 28a-f show croust be notified at	2244 Thomas Run Road 21015	United States
	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
20 safte	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto R  1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto R  1 Yes 2 No In	Canaihu
15-002 15-002 72 hours "natural", edical Exa	3 Ma Widowed 4 □ Divorced Year or Dates:	White
21215-0020 d within 72 hours after glane. The Madical Examine to the Madical Examine	15. Decedent's Educetion (Specify any highest grade completed) (Give kind of work done during most of workin life. DO NOT use retired)	16b. Kind of Business/Industry
withir and the man	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	Home
T D BERT O	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maiden Sumame)
ylan ylan ylan wantel Mantel Mantel Mantel Mantel Mantel	Isaac Minton Rosa	Elliott
Maryland 2.  A2 should be filed v the ond Mantel Hygia traumatic event, to		Route Number, City or Town, State, Zip Code) 21001
Note, Maryland 212 set 1 and 2 should be filed within tof Health and Mantel Hygiane. If filem 27 is marked other than or other traumatic event, the Maryland To Be Comp	Sandra Horton/Daughter 529 Aldino-Stepney	
other item	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
T C I D C I	Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Bel Air Mem. Gardens 9	/22 Bel Air. Maryland
Baltimore, M Baltimore, M permit. Pages 1 end 2 Department of Health e important: if item 27 it any injury or other tra once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	on Funeral Home, P.A.
- m 88 5 8	Jarrettsville,	Maryland
	23a. Perl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on eacturine.	respiratory arrest, Approximate Interval Between
Physician	SHOCK, OF Heart failure. List only one cause on eachpille.	Onset and Death
/Medical	Immediate Cause (Final disease or condition resulting in death)  a. My gladial Marchim	
Examiner	resulting in death)  Due to (or as a consequence of):	
68760, ficate be axecuted physician and ts the bunish transit edical Examiner	hyperterrin	year
and I-tran	Sequentially list conditions, if any leading to immediate	
60, be as ician buria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):	
( 68760, artificate be axecuted ing physician and a as the burial-transit Medical Examir	resulting in death) Last  Due to (or as a consequence of):	
	d	1
P.O. BOX that the death ce ed by the attendi deteched for use	Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death
t tha de by the teched		1 Yea 2 No 3 Probably 4 Unknow
IS, P	sairal decibits anomica	
Il Records, P.O. Boy The law requires that tha death ce are has been signed by the attend page 2 should be deteched for us. Completed by Physician/	· ·	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
aw re is bee		completion of cause of death?
Relaw		1 Yes 2 No 1 Yes 2 No
of Vital Re Physician: The lat rthis certificate has aral director, page 2	25. Was case referred to medical examiner?	(Check only one)
of V hysici his ce il direc		ne 5 ☐ Residence 6 ☐ Other (Specify)
Division of Vital Records, P.O. Box ior Attending Physician: The law requires that the death cert after death.  Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be datached for usa ertification: To Be Completed by Physician/N	1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe how injury occurred
isio ttendii death. ctor: At y the fu	2 Accident investigation M 1 Yes 2 No	
iviend the different in by	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
oltai o urs at illed i	CO- Co-Miles (CNC-MILE Physical Table has been death and an house dath as	-44
Division C  •• Hospital or Attending PI  •• A hours after death. •• Funeral Director: After the pletely filled in by the funeral edical Certification:	29a. Certifier  (Check only one)  Check only one one one one one one one one one one	
Divisio To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the ti	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
+ 3 + 5	1 (1/VUlly um ) 112025	alialos
19	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	9/10/06
4'	akun Mille un 610 Maistril Ad Me	1 Am Mn 27014
State	31. Date filed (Month, Day Year) 5 2000 32. Registrar's Signature	
Registrar	SET 40 2008 Mileur to Species	· · ·

State of Maryland / Department of Health and Mental Hygiene 200630356 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 19-08-**Physician** 2006 MARGARET EWELL FISHER /Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death Examiner alish ury Wicomico Hospice the Lake If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2□F 75 Yrs. 230-34-6698 Director 05/20/1931 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ral', or Iteme 23a or 28a-f ehov Examb at must be notified at 1 ☐ Yes 2 X No MD Worcester Pocomoke City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2624 Stockton Road 21851 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "natural" I Hygiene. other than "natura rent, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 le marked o traumatic eve and Mental Beulah Parker Merrill Ewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If Item 27 | Health Faye Clayton/ Cousin 3841 Church Point Rd., Virginia Beach, VA 23455 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of H
Important: If Ite
eny Injury or ot
once. 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cem. 09/12/2006 Pocomoke City, Md 21851 22. Name and Address of Facility Holloway Funeral Home, P.A., 21. Signature of Funeral Service Licensee 103 Linden Ave., Pocomoke City, Md 21851 ean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MRTASTATIC **Physician** LHNE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-translt To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 □Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 1 ☐ Yes : After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Apatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROWWOOD CT. SALIS BURY and 21801 BA 10 WARKS 26266 CHULAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1 2 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2006 30357 -1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** HANNAH MARGARET FILER SEPT /Medical 18 2006 12:26P.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12229 CARLOS RD SW FROSTBURG ALLEGANY | Honor | Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 4/26/1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 92 Months 1 M 2 XF Director 214-42-4236 MARYLÁND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County item 27 is marked other then "naturel", or Items 23s or 28e-f show other treumstic event, the Modical Exertities I must be a cutified at 1 ☐ Yes 2 X No Director ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12229 CARLOS RD SW 21532 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: þ Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOURDINE MICHAELS DAVIES BENJAMIN DAVIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12229 CARLOS RD SW FROSTBURG MD 21532 Pages 1 and 2 s nent of Health an 12229 CARLOS RD SW BETTY KNOTT/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Importent: If any injury or once. FROSTBURG MEMORIAL PARK 9/23/06 FROSTBURG MD ' 4 ☐ Donation 5 ☐ Other (Specify) 60 W. MAIN ST. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FROSTBURG, MD 21532 SOWERS FUNERAL HOME, P.A. 1 Sowers MO0547 lan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARCINOMA LEFT disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DiaBETES 1 Yes 2 No 3 Probably 4 Unknown Completed EMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No investigation Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-0013166 pelon ul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANN TEMPSCE tuo 42 reaut 14 31. Date filed (Month, Day, Year) 32 egistrar's Signature 2-1532 State SEP 2 5 2006 Registrar

			For State Registrar	State of M		/ Depa		of H	ealth a		ental Hyd	_		30358
	Physicia		1. Decedenl's Name (First, Middle, La Arthu	r Edward G	Grogan						2. Date of Dea Month EPTEME	Day BER 10	Year 2006	3. Time of Death 06.25 A M
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, To	own, or	Location o			4c. County	y of Death	
			St. Mary's Hosp		- (1 1	4 6 1 4 5 4 5 1 1	Leo		dtown		Date of Blat		Mary	
	Funeral Director		5. Social Security Number 6. S 579–10–0976	7. A9	je (In yrs. las 90	Yrs.		Days	Hours	Min.	B. Date of Birth (Month, Day October 2	22.1915	Mary.	place (State or Foreign intry) Land
	<b>D</b>		Usual Residence of Decedent		140 01									
	death with the Maryland ms 23a or 28a-f show rmust be notified at	5	10a. State 10b. County	-10	10c. City, 7									10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	rect	Maryland St. Mary	S	1	Avenue	10f. Zip C	ode			1	10g. Citizen of	What Cou	intry?
	h with		23263 Coltons Point 1	Road			20	0609				U	ISA	
٥		Funeral Director	11. Marital Status 1 □ Never Married 2 ☼ Married	12. Was Decedent Armed Forces? 1 X Yes 2 L If Yes, Give			Was Deceder		spanic Origin, Mexican  Specify:	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14. Rai Bla Specii	ick, White,	ican Indian, , etc.
3	ural',	d by	3 Widowed 4 Divorced	Year or Dates:							-		Who	
Maryland 21215-0036	filed within 72 hours effer Hygiene. Ither than "natural", or Ite Int. the Medical Exemina	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual kind of work DO NOT use	done di retired)	tion uring most )	t of working	g	16b. Kind of B	susiness/ir	idustry
717	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Owner	:/Operat	or				luminum	Wholes	æle
פ	be file tal Hyg d othe event,	Bec	17. Father's Name (First, Middle, Last	)				ĺ				Maiden Sumai	me)	
<u>\</u>	should I	ဥ	Robert Herman Grogan						Bertha					
<u>a</u>	12 12 14 17		19a. Informant's Name/Relationship ( Lois Ruth Morris / W		1		-					r, City or Town Cyland 20		5 Code)
Baltimore,	Pages 1 and nent of Healt int: If itsm 2 iry or other		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	Removal from State	20b. Plac	e of Disponent	osition (Name matory or oth	of er place		Septe	ember	20c. Location	- City or T	
	permit. Pages Department of I important: If Its any injury or o		4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice	7	()	2:	2. Name and	Addres	s of Facility	14, 2	- 25000000000	Bushwood	rery	riand
ă	Ded Time		Muchael	Lard	mer	ノ P.	U. Box	2/0,	Leona	ardtown		and ZUOSU	)	
			23a. Part1. Enter the disease, or comshock or heert failure. List only	one cause on each i	d the death. ine.	Do not en	ter the mode	of dying	, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
,	Physician /Medical	Ì	Immediate Cause (Final disease or condition resulting in death)	a. Cere	bor	asc	ula	(	ec	ecd	2ent			Her A 5
	Examiner		1	Due to (or as	a conseque	nce of):								
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	α σεΤισογασι	ive of).								
	acuted ind transil	Examiner	r any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
60,	le be executed ysicien and e burial-transit	calEx	resulting in death) cast	Due to (or as	a conseque	nce of):								
289	physics the			_ d										
XOX	law requires that the deeth certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			∃Ectopic preg	gnancy					ate of deliv	•
-	at the deel by the att	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□ Unknown			Other (spec					M	onth	Day Year
J.	that the	Phy	Part II. Other significant conditions	contributing to death t	out not resulti	ng in the u	inderlying cau	use dive	n in Part I.		23e. Did to	bacco use con	tribute to t	the cause of death?
g O	uires I signi Id be	d by		•		•	, ,	•			1 U Y	es 2 🗆 No	3 Pro	bably 4 Unknown
် ဝ	w requir s been si should!	lete					-				24a. Was a		Were auto	opsy findings available
Vital Records,	Physician: The lav r this certilicete has ral director, page 2 :	Completed									autop: perfor 1  Yes	sy med?	prior to co death? 1 \( \text{Yes}	ompletion of cause of 2 21No
<u> </u>	sian: artifice ctor, p	Be C	25. Was case referred to medical examiner?							of Death	Check only or			
ō	hysic this ce al dire	ု	1 ☐ Yes 2 No	Hospital: Inpati		VOutpatie			401140			ence 6 □Ot		fy)
S C	fing Afte	tlon:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	ly Year)	8b. Time o Injury	M 280	c. Injury Work	at :? /es 2 ∐1		sa. Describe n	ow injury occur	rred	
Division	or Attanding Physician: after death. Director: After this certific in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of In	jury - At hom lc. (Specify)	e, farm, st					Bf. Location (S City or Tow		ber or Rur	al Route Number,
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	235 Cartifier 1 X Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of examinatio	edge, deal n and/or in	h sentinad at evestigation, in	t the tim	e data an pinion, deal	d place, ar th occurred	nd due to the o d at the time, o	nues(e) and in late and place,	anner ac t and due t	rtated to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	<b>\</b>	/		29c.	License	number		Z	29d. Date signe	ed (Month,	Day, Year)
•			) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ma 9	tu		/	01	428	-		9-1	2-0	6
					eath (Item 2		Print)							1-
			WILLIAM BOYD PO		LEONAR		N MD 20	0650	)					
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 3 2		rar's Signatui		- Marie							
DH	MH 17 Rev 1/2			J. J. L. L. L. L. L. L. L. L. L. L. L. L. L.	J K	1								
						ORIG	INAL							

ARTHUR GROGAN

State of Maryland /	Department of Health and Mental Hygiene	2006

		State of Maryland / Department of Health and  1 - State of Maryland / Certificate of Death	7	ne 2006 30359
		Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Physi		Donald Lester Garrison		O7 2006 8:20A <sup>M</sup>
	dical	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat	1	4c. County of Death
Exam	uner	Continuum Care at Sykesville Sykesville		Carroll
Funera	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign Country)
Directo		472-18-6148 1 M 2 F 83 Yrs. Months Days Hours Min.  Usual Residence of Decedent	06/16/1	923 IA
yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Director	MD Carroll Finksburg		1 ☐ Yes 2 ☐ No
or 28	i e	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
th wi	je.	3934 Sykesville Rd. 21048		USA
ems ems	를	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (5	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mantal Hydrone Montal Hydrone Mantal Hydrone I to Health and Mantal Hydrone I to Health and was a second many injury or other treumetic event, the Modeal Examiner must be notified at	by Fu	1 □ Never Married 2 ∰ Married 1 1 1 1 1 Never Married 2 ∰ No Specify:		Specify: White
72 hours af netural", or	D D		16h	. Kind of Business/Industry
net "net	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Sive kind of work done during most of wo	rking	. Kind of Business/industry
withir and then then then	E	Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army		Military
Hygi Hygi ther	ပို	17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Middle, Maid	
ould be fill Mental H arked oth	Be	Lester L. Garrison Pearl	L M. Jone	S
mari meti	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R	ural Route Number, Cit	ty or Town, State, Zip Code)
d 2 st ith and 27 Is r		Francis D. Garrison-Wife 3934 Sykesville Rd	Finkeh	urc MD 21049
Heal Heal		20a Method of Disposition 20b. Place of Disposition (Name of		Location - City or Town, State
nt of		1 Burial 2 #Cremation 3 Removal from State 4 Donation 5 Other (Specify)  1 Carroll Cremation 09/	/08/06 H	ampatand MD
rmit. Pages spartment of I portent: If Its	ش	21. Signature of Funeral Service Licensee 22. Name and Address of Facility E		ampstead, MD
Dep	ouc	934 South Mair	Street 1	Hampstead,MD 21074
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia		Approximate Interval Between
Pnysicial /Medica Examine	al er	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):		nset and Death
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or hips) that initiated events resulting in death) Last  C		
certificate oding phys	Jed	IF FEMALE:		
the death ceing the attendir	hvsiclan/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delivery  Month Day Year
requires that the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The lar	ompleted		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 \[ \subseteq \text{ss} = 2 \[ \subseteq \text{No} \]
vicien: The certificate rector, pag	Be	25. Was case referred to medical 26. Place of De	ath (Check only one)	
nysic nis ce direk	Į.	1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. Nursing	Home 5 Residence	e 6 ☐Other (Specify)
or Attending Physicien: uffer death. Director: After this certifics in by the funeral director.			28d. Describe how in	njury occurred
ath.	atio	1 Natural 5 Pending 2 Accident investigation M 1 Yes 2 No		
or Attending after death. Director: Afte	tific	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
tel on Israelia	Certification:			
To the Hospitel or Atlandi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Medical		e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th Mithin Fo th	Me	29b. Signature and title of partifier 29c. License number	29d.	Date signed (Month, Day, Year)
. 1	IN	D90581	37	9/7/06
WSL 3+	1/1/1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Lus 295 Stone Art 54 307 West	ninste	MO 21157
	State	31. Date filed (Month, Day, Year)  32. Redistrar's Signature		
Regi		No. M. Magalia		

		i	For State Registrer	of Maryland / De	epartment of He Dertificate of D	ealth and M Death		ne No. 2006	30360	
	Physici /Medic		Chamidan Chant Cladhill			2. Date of Death Month September	Day Year	3. Time of Death		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland O bepariment of Heelih end Mental Hygiene.  Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow and important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow and more any injury or other traumatic event, the Medical Examinar must be notified at an one of the contract of the more and the contract of the more and the contract of the more and the contract of the more and the contract of the more and the contract of the co	ner	4a. Facility Name (If not institution, give street and number)  Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 2 19-20-1820 1 № № 2 F 85 Yrs.		Hager	4b. City, Town, or Location of Death  #agerstown  If Under 1 Year   If Under 24 Hrs.   8. Date of Bir Months   Days   Hours   Min. (Month, Days)		4c. County of Death  Washington  Py Year 1921  9. Birthplace (State or Foreign Country)  Manual and		
Baltimore, Maryland 21215-0036			Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. In:					aryland  10d. Inside City Limits  1 □ Yes 2 ☒ No		
		Funeral Directo	10e. Street and Number  21128 Jefferson Blvd.  11. Marital Status 12. Was Decedent Ever in U.S.		10f. Zip Code	10f. Zip Code  21783  . Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			Og. Citizen of What Country?  U.S.A.  14. Race - American Indian,	
		þ	Armed I	2⊠No Sive Dates:	1 ☐ Yes 2X No Specify:			Black, White, etc.  Specify: White  16b. Kind of Business/Industry		
		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  8  17. Father's Name (First, Middle, Last)		Give kind of work done during most of working life. DO NOT use retired)  Mechanic  18. Mother's Name (First, Middle,			Auto		
		To Be	Ernest Gladhill  Mary McKissick  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
			Sheridan Lee Gladhill  20a. Method of Disposition  ↑ Calculation 2 □ Cremation 3 □ Removal fror 4 □ Donation 5 □ Other (Specify)	20b. Place of D cemetery,	07 Green C1 isposition (Name of crematory or other place) dge Cemeter	Septemy 22, 2	ate 20c ber 2006 Th	Location - City or I	Town, State  Mary land	
Ball	Departition Depart		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Davis Funeral Home  12525 Bradbury Ave. Smithsburg, Maryland 21783  23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate							
Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed THE TWIND 24 hours after death. This certificate has been signed by the ettending physician and THE TO the Funeral Director. After this certificate has been signed by the ettending physician and THE TO the Funeral Director, page 2 should be detached for use as the burial-transit or DI DI DI DI DI DI DI DI DI DI DI DI DI	e Completed by Physician/Medical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  List only one cause on leach line.  Interval Between Onset and Death							
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			40	23d. Date of delivery Month Day Year			
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown				
			25. Was case referred t edical			26. Place of Death	24a. Was an autopsy performed 1 Yes 2	prior to co	topsy findings available completion of cause of	
		To B	examiner/ 1 Yes 2 No  Hospital: 1 patient 2 EP/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
		Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Special County of Special Coun		M 1 Tyes 2 No  At home, farm, street, factory, office 28f. Location			n (Street and Number or Rural Route Number, Town, State)		
		Medical Ce	29a. Certifier  (Check only one)  1 Vertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	Toth Toth comp	M	29b. Signartule and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
	Sta Registr		ROBIERT BRULL MY	1459 f	DOTOMAC.	ST. F	HAGERS	TOWN H	021142	

			1 - For State Registrar	State of Maryland / I	Department of Health  Certificate of Deat	h	iene 2006	3036
	Physici /Medio	cal	Decedent's Name (First, Middle, Last     A V V     S     4a. Facility Name (If not institution, give	Hollin	4b. City, Town, or Location	2. Date of Deat Month September	Day Year	3. Time of Death
	Examir Funeral Director	ier	PENINSULA REGIONAL  5. Social Security Number 6. Se	Medica CENTER	5,445,84	IRY der 24 Hrs. 8. Date of Birth	Vear 9. Birthe	lace (State or Foreign
	death with the Maryland ims 23a or 28a-f show if must be notified at	irector	10a. State 10b. County	MACK C	n or Location  h i N CO te i  10f. Zip Code	ngue	1 0g. Citizen of What Cour	0d. Inside City Limits  1
920	or its	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - Americ Black, White, Specify: W	can Indian,
3 21215-0036	d within 72 giene. ir than "nat	e Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)  HOUSE W	nost of working  Fe other's Name (First, Middle, M	16b. Kind of Business/In	dustry
Maryland	12 should be h and Mental 7 is marked o fraumatic eve	To Be	FTANKLIN (19a. Informant's Name/Relationship (7)	po, Print) 198 HOllinger S	o. Mailing Address (Street and Num	Helen	HAi	4
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 1 once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	lemoval from State	of Disposition (Name of rry crematory or other place)  AWD (Ye.)  22. Name and Address of Fac.	9/11/96	Chi NCO,	NA.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do no cause on each line.  Pullulum  Due to (or as a consequence	not enter the mode of dying, such	CKEN CITY		Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence  Due to (or as a consequence				
P.O. Box 68	The law requires that the death certifica 11e has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	a 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
Records, P	law requires that as been signed t 2 should be det	Completed by P	Part II. Other significant conditions co	ntributing to death but not resulting to	in the underlying cause given in Pa	1 □ Ye	n 24b. Were auto	pably 4 Unknown
		Be Com	25. Was case referred to medical examiner?			autops: perform 1 □ Yes 2 ace of Death (Check only one	death? 1 ☐ Yes	mpletion of cause of
Division of Vital	S S	Certification: To	1 Yes 2 No  27. Manner of Death 1 Watural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of lnjury at Work?  M 1 Yes 2	Nursing Home 5 Reside  28d. Describe ho		v)
DİXİ	P # # ⊆	i Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fabuilding, etc. (Specify) sician: To the best of my knowledg		City or Town		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Example of certification of certifi	ner: On the basis of examination ar and manner stated.	29c. License number	death occurred at the time, da	ate and place, and due to	Othe cause(s)
	F 3 F 8		30. Name and address o person who c	Ampleted cause of death (No. 222)	D367	283 20 SAUS G	Sept. 10,	2006
7	1 6 Sta	ite_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	on, hus. Pre	ac SAUS B	ary m	). 21801
	Registr		SED 12	996	Smarth)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 30362 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 13 2006 **Physician** Thomas Emanuel Higgs, Jr. 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Hours | Min. | February 4,1919 Birthplace (State or Foreign Country)
 Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 100 M 2□F Months Days 87 577-24-8259 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then \*natural', or items 23a or 28a-f show may injury or other traumatic event, the Mardical Examinar invatible nuffilled at once. 1 ☐ Yes 2 No Director St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41723 Breton Beach Road 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Emanuel Higgs, Sr. Lucretia Florine Bowles ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Marie Higgs / Wife 41723 Breton Beach Road, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1XXBurial 2 Cremation 3 Removal from State Our Lady's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 16, 2006 Leonardtown, Maryland 22. Name and Address of Facility
Mattingley-Cardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorra gz LINTOR (52nial **Physician** /Medical Due to (or as a consequence of): Denal failusz 17975 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 4(415 attending physicien and for use as the burial-transit Alzhermer's disease. The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 6 mp 44 Sc ma 1 Yes 2 No 3 Probably 4 Nunknown Completed De menna 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 € No this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) To the within 2.
To the complet 29b. Signature and pitter of certifier 29c. License number 29d. Date signed (Month, Dey, Year) My). 0061719 September 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhananjay Bhavsar, M.D. 25500 Point Lookout Road, Leonardtown, Maryland 20650

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

SEP 1 5 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Pegistrar's Signature

		•	1 - For State Registrar	State	of Ma	ryland / I		artment of F tificate of		d Mental F	lygiene Reg. No	200	6	3036
			Decedent's Name (First, Mide	fle, Last)						2. Date of Month,			-	Time of Death
	Physici /Medic		Gary Lance Hu							Septe	nber	5,2004		228 M
1	Examin	er	4a. Facility Name (If not institution Peninsula Region			cerrex		4b. City, Town, o			4c.	. County of Deat		
	Funeral		5. Social Security Number	6. Sex	-	(In yrs. last bi	rthday)	If Under 1 Year	ff Under 24 F	Irs. 8 Date of	Birth	Nr Com	hplace	(State or Foreign
	Director		219-46-4280	1⊠M 2□F		59	Yrs.	Months Days	Hours M	12/27	1946	Mar	untry) yIai	nd
	and w		Usuel Residence of Decedent  10a, State 10b, Count	у		10c. City, Tow	m or Lo	cation					10d. fr	nside City Limits
	Maryli f sho	ř	DE Sus	sex		La	urel							☐Yes 2X No
	r 28a	irec	10e. Street and Number					10f. Zip Code			10g. Cit	izen of What Co	untry?	
	23a c	rai D	11478 Whites	ville Ro	ad			1995	6			USA		
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Modical Examinet must be multind at	by Funeral Director	11. Maritaf Status  1 Never Married 2 Ma	rried Armed	ecedent Ev Forces? s 2 X No Give		1	Was Decedent of H fYes, specify Cub 1 ☐ Yes 2幫 No	tispanic Origin? an, Mexican, Pu Specity:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: Whi	e, etc.	dian,
21215-0036	hour	ed p	3 ☐ Widowed 4 ☑ Divorce	nt's Education	r Dates:	16a	. Deced	lent's Usual Occup	ation		16b. K	ind of Business/		,
215	within 72 ene. than "nai	Completed	(Specify only high Efementary/Secondary (0-12)	est grade complete	ed) e (1-4or 5+		(Give	kind of work done OO NOT use retire	during most of	working				
	filed will Hygiene other the	Com	12		0 (1 401 01	<u></u>	Ca	rpenter					Con	struction
Maryland	should be file nd Mental Hy marked oth imatic event	To Be	17. Father's Name (First, Middle Clyde Hudso							Name (First, Mide evieve B			ph	
	nd 2 lith a 27 ls		19a. Informant's Name/Relation Terry Kohlhoff		r			ng Address (Street 2 Old Oce						
altimore,	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other		om State	cemete	ry, cren	sition (Name of natory or other pla .1s Cemet		Date /10/06		ocation - City or DE		State
Balt	permit. Pag Department important: I eny Injury o once.		21. Signature of Funeral Service	Licensee	, ·			Name and Address Nort Fune		ne,13 E.	Grove	st,Del	mar	DE 19940
	_		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications the	at caused t	he death. Do	not ent	er the mode of dyi	ng, such as card	diac or respirator	arrest,		Inter	roximate rval Between
	Physician		fmmediate Cause (Finaf disease or condition	_ a	(	ardio	20	arra	w/Div	ia			Ons	et and Death
	/Medical Examiner		resulting in death)	Due	to (or as a	consequence	of):	11/		"1 7	/ \	7	_	34
	4	e	Sequentially list conditions, if any, leading to immediate	b. — Due	to for as a	COLOR	of):	Myc	Carollet	4nt	Luf			(UMLRS
	ficate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>		3000		Euro 1	Profes	(1) 200	×.		(	3 473.
o,	cate be executed physicien and the burial-transit		resulting in death) Last	Due	to (or as a	consequence	of):	/						
8760	ate by	dical		d			- '	/						
.O. Box 6	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pr	re birth 2	f pregnancy   Detel death   Fetel death		Ectopic pregnanc Other (specify)	/		-	23d. Date of defi Month	ivery Day	Year
О.	that the bound of the by the bound of the bo	by Ph	Part II. Other significant condi	tions contributing t	o death but	not resulting	in the u	nderlying cause giv	en in Part I.	23e. Di	d tobacco u	use contribute to	the cau	use of death?
rds	w requires been sign should be		Chr	sic.	Reul	1	ask	ien_		1[	☐Yes 2	□No 3□Pre	obably	4 XUnknown
Division of Vital Records,	nysician: The law requires that the ns certificete hes been signed by th I director, page 2 should be detach	Completed							<sub>\\</sub>	pe	rtopsy rformed?	prior to death?	completi	ndings available ion of cause of
a		Be C	25. Was case referred to medic	al					26. Pface of I	1 ☐ Ye: Death (Check on:		1 ☐ Yes		40
<u>&gt;</u>	hysic his ce	To	examiner? 1 □ Yes 2 ᡬNo			t 2 🗆 ER/O	utpatien		4   Nursiti	g Home 5□ Re	sidence	6 □Other (Spec	cify)	3=1
U C	l or Attending Pheter death. Director: After the in by the funeral	ion:	27. Manner of Death  1/ Natural 5 ☐ Pend	ing (A	ite of Injury fonth, Day		Time of Infury	Wo		28d. Describ	e how injur	ry occurred		
S	death ctor: y the t	licat	3 Suicide 6 □ Coul		ace of Injur	v - At home, fa	arm str	M 1 ==	Yes 2 □ No	28f. Location	(Street an	nd Number or Ru	ral Rou	ite Number
<u>≥</u>	effer Direction	Certification:	4 Homicide	mined 288. Pi	ilding, etc.	(Specify)		osi, lastory, omos		City or	Town, State	a)		to rvanico,
	To the Hospital or Attending Physician: within 24 hours eller death. To the Funeral Director: Atter this certifice completely filled in by the funeral director.	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To il Examiner: On th and m	the best of e basis of e anner state	examination ar	e, death	occurred at the ti restigation, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time	ne cause(s) e, date and	) and manner as d place, and due	stated. to the o	ause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certif	er	3	///		29c. Licens	e number		29d. Da	te signed (Monti	n, Day,	Year)
	0		De	10	/	ha	14	10-	2003	7		9/5/6	2	
	10 100		30. Name and address of person BENITO S.	CHAN	13	ath (ftem 23a)	(Туре,	Print) )/V/3/a	Sf.	SM 3	0/5	clish	MI	12/804
	Sta Registi		31. Date filed (Month, Day, Yea SEP 0	8 2006	Line Contraction of the Contract	's Signature	A	rade						/

			1 - For Amend Item 2	3a,25 State of	<b>M</b> arylar <b>359.09</b>	719/0 <del>21</del>	artment of F	lealth i	and Me	ental Hyg	giene Reg. No.	200	5 3	0364
			Decedent's Name (First, Middent)	lle, Last)		-			2	2. Date of Dea	ath			ne of Death
	Physici /Medio		Snaron	L HU	ivd					Month O	O		_	142 AM
	Examir		4a. Facility Name (If not institution				4b. City, Town, o				4c.	County of De		
			UNIVERSITY					MOV				NIA		
100	Funeral		5. Social Security Number 219-46-4127	6. Sex 1 □ M 2√2 F	7. Age ( <i>In yr</i> s. 5.9		If Under 1 Year Months Days	Hours	Min.	B. Date of Birtle (Month, Day (ar 17	v, Year)		country)	ate or Foreign
	Director		Usual Residence of Decedent		55			l	ĮM	ar 17	19	4/ M	aryla	ina
	yland		10a. State 10b. Count	у	10c. Ci	ty, Town or Lo	cation						10d. Insid	de City Limits
	a-fs	Director	MD Ken	t	Cł	nester	town						1 []	Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What (	country?	
	ath w	ral	4898 Cliff				2162					S.A.		
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "neturel", or items 23e or 28e-1 show event, the Mcdical Examble in usite in cultiled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma  3 □ Widowed 4 ☑ Divorce	If Yes, Giv	ces? 2 x No e		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Or an, Mexica Specify:		ify Yes or No- ican, etc.)		14. Race - An Black, Wh Specify:		
Ö	2 hou		15. Decede	nt's Education		16a. Dece	dent's Usual Occup	ation			16b. Ki	nd of Busines	s/Industry	
215	within 7 ene. then "n	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	life.	kind of work done DO NOT use retired	during mos d)	it of working	7	Lif	e Ins	uranc	e
2	filed within Hygiene. other then ant, the Me	Con	12			Ins	urance	Sa1e	S		Com	pany		
nd	be filed v tal Hygie d other t	Be	17. Father's Name (First, Middle							First, Middle,	Maiden	Sumame)		
<u> </u>		င္	Philemon Di						h Le					
Maryland 21215-0036	d 2 sh h and 7 Is n traun		19a. Informant's Name/Relation Deborah Brow		e)		ng Address (Street Dorlon				-	MD •		
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of		Da			cation - City o		
nor	0 0		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (		State	cemetery, crer	natory or other plac emation	. 1	9/10	/06		yrna,		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatur d Hungral Service		/	G.22	Name and Addre							Schaech
	Ø □ 〒 @ O			9	M0051	10 11	8 West	Cros	s St	. Ga1	ena	, MD.	2163	35
			23a. Part . Enter the disease, o shock, or heart failure. Lis	it only one cause on ea	ach line.	in. Do not ent	er the mode of dyli	ig, such as	cardiac or	respiratory an	rest,			l Between and Death
k .	Physician /Medical		Immediate Caúse (Final disease or condition resulting in death)	a. PNC	umon	19							1-2	months
	Examiner			Due to (	or as a consec		uadriple		. c					
	4	er	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a consec		ural ab	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_		7			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	¶ Cerv	vical Epi	idural Al	180255		- 11	11/ No	DER			
ó	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (	or as a consec	quence of):		j	BIXLT	MEDICAL EX	Willes			
8760,	ate be hysici the bu	dlcal		d	_			man	APPROVED B	N w.				
9	ertifica ing pl	Med	IF FEMALE:	I			75	TON					F	
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		rth 2 Feta	al death 3 □	Ectopic pregnancy				4	23d. Date of d Month	elivery Day	Year
	the de	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unkno	ant at time of c	ieath 5	Other (specify)							
P.0	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	/ Ph	Part II. Other significant condi-	ions contributing to de	ath but not res	sulting in the u	nderlying cause giv	en in Part I		23e. Did to	bacco u	se contribute	to the cause	of death?
rds	quires n sign ald be	d by	a nadriplea;	9						1 □ Y	'es 2[	□No 3□F	robably 4	Unknown
Vital Records,	law requir as been si 2 should I	Completed	, 0,,,							24a. Was a	an	24b. Were a	utopsy findi	ngs available
Re	The lay	шо								autop perfor 1  Yes		prior to death?		of cause of
ital		0	25. Was case referred to medic	al				26. Place	e of Death (	Check only of		1010		
	d is	To B	examiner?	Hospital: 1 1	npatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nı	ursing Home	e 5 ☐ Resid	lence (	5 □Other (Sp	ecify)	
n of	ding Phy.  After thi funeral		27. Manner of Death 1 ★Natural 5 □ Pend	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28	ld. Describe h	ow injur	y occurred		
sio	Attending ir death, ector: After by the fune	catl		tigation				Yes 2 🗆						
Division	o ii e	Certification;	4 Homicide deter	mined 200. Flace	of Injury - At h ig, etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factory, office		28	If. Location (S City or Tow	itreet an m, State	d Number or F )	Rural Houte	Number,
	Hospitel or 24 hours afte Funerel Dir itely filled in		29a. Certifier 1 Certify	ing Physician: To the	hest of my kno	wledne death	occurred at the tir	ne date ar	nd place, an	d due to the d	sauco/c)	and manner	is stated	
	24 hose Fun	Medical	(Check only 2 Medics one)	I Examiner: On the ba	isis of examina	ation and/or in	vestigation, in my o	pinion, dea	th occurred	at the time, o	date and	place, and du	e to the cau	se(s)
	To the Hospitel of within 24 hours at To the Funerel Completely filled it	Me	29b. Signature and title of certif	er			29c. Licens	e number			29d. Dat	e signed (Mor	nth, Day, Ye	ar)
)		1	Na dra cra	morn,	1D		- 1	740	3		50	otento	ero	7,2006
	-		30. Name and address of perso	who completed caus	e of death (Iter	m 23a) (Type,	Print)				-	7 1 11 10		-, -
	0		Nadia Chau	32. Re	NIV.O	f MD	225	. Gre	ene	stree	+1	Baltin	rove, v	7,2006 4D 2120
	Sta		31. Date filed (Month, Day, Yea	32. R	egistrar's Signa	aftire .								
	Registr	टा	CED 1 9 ZUUb	是一种人的 ( )	and the same									

State of Maryland / Department of Health and Mental Hygiene 2006 1 - For Stata Ragistrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September 9, 2006 **Physician** Helen Rebecca Jones 6:40 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year Days Min. Months Hours 1 □ M 2 1 F 219-82-5909 84 Yrs Nov 30, Director 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or liams 23a or 28a-f show the Woolcal Examinational be nutified at Westminster 1 Yes 2 □ No **Funeral Director** Maryland Carroll 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 202 East Green Street 21157 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: white Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Domestic Worker Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 Is marked other t jury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E. Harry Katie Virginia Baggett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Larry J. Jones, son 3545 Lawndale Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Lorraine Park Cem. 9/13/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01191 Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The taw requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year 0 in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 2 ER/Outpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after dec. 1 TYes 2 No 6 Could not be 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month; Day, Year) 06 WSL 0061206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D.O. anover 31. Date filed (Month, Day, Year) State Com & Speck Registrar 2006

	-01	1- For State Registrar	tate of Marylan		artment of			iene .g. No.2006	30366
Physi /Med		1. Decedent's Name (First, Middle, Last)  Carol Vivian Jackso	on				2. Date of Deat Month Septemb	Day Year Der 7, 2006	3. Time of Death 9:20 a.M
Exam		4a. Facility Name (If not institution, give stree Montgomery General			4b. City, Town	o, or Location of D	eath	4c. County of Deat	ntgomery
Funera Directo		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da	ar If Under 24 I	Hrs. 8. Date of Birth (Month, Day, Dec. 24.	Year) 9. Birt	hplace (State or Foreign nuntry) cyland
Maryland -f ehow	tor	Usuel Residence of Decedent   10a. State		y, Town or Lo			-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ary Itang < 1 < 1 3-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other than *naturel*, or iteme 23a or 28e-f ehow umatic event, the Medical Examinat must be notified at	Funeral Director	1 ☑ Never Married 2 ☐ Married	Nas Decedent Ever in U. Armed Forces? I □ Yes 2 ☑ No f Yes, Give		Vas Decedent of Yes, specify C	20853 ol Hispanic Origin? cuban, Mexican, Pe	? (Specify Yes or No- uerto Rican, etc.)	USA  14. Race - Ame Black, Whit	oncan Indian, e, etc.
d within 72 hours at giene. or than 'naturel', or it a Medical Exam.	Completed by	3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade continuous properties)  Elementary/Secondary (0-12)	Year or Dates:	16a. Deceo	ient's Usual Oc	cupation	working	Specify: To the specific of Business.	White
Hygi ent.	To Be Cor	5 17. Father's Name (First, Middle, Last) William C. Jackson			Never		Name (First, Middle, M hy Vivian		9
nd 2 oith a 27 is		19a. Informant's Name/Relationship (Type, William C. Jackson	/ Brother		10723 M	leadowhil		lver Sprin	g, MD 20901
Definition of the post of the		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remod  4 ☐ Donation 5 ☐ Other (Specify)	Valifolii State	ropolita	sition (Name of natory or other an Cremat	ory	2006 A	20c. Location - City or .lexandria,	
Depart Inpo		21. Signature of Funeral Service Licensee  Lin Signature Complete Signature Licensee  23a. Part 1. Enter the disease, or complication		50	0 Unive	rsity Bl	s Funeral	ver Spring	, MD 20901 Approximate
boy 200, to a control of the physician and bhysician and surfar transit surfar transit.	Ical Examiner	shock, or heert failure. List only one call Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of the consequence of t	uence of): $\sqrt{S}$ ( $SA$ ) uence of): $\sqrt{A}$	CARDIO	VASCUlar	MSEASI	9	Interval Between Onset and Death YEARS  YEARS  65 Years
s that the death certific ned by the attending p	Physician/Med	in the past 12 months?	f yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregna Other (specify			23d. Date of del Month	ivery Day Year
w requires that been signed be should be detailed	र्व	Part II. Other significant conditions contribu	uting to death but not resu	ulting in the ur	nderlying cause	given in Part I.		acco use contribute to s 2 1 No 3 □ Pr	the cause of death?
ysician: The law requires t ysecution in the law requires t is certificete has been signe director, page 2 should be	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to (	atopsy findings available completion of cause of
ding Phy I. After this funeral d	ation: To Be	25. Was call referred to medical examiner?  1  Yes 2 No Hosp  27. Main 1 Death 1 Natural 5 Pending 2 Accident investigation	ital: 1 □ Inpatient 2 ↓↓ 8a. Date of Injury (Month, Day Year)	R/Outpatien 28b. Time of Injury	28c. li		Death (Check only one g Home 5 Reside 28d. Describe ho	nce 6 □Other (Spe	cify)
i giệc c	Certification:	4 Homicide	8e. Place of Injury - At ho building, etc. (Specify	<i>(</i> )			City or Town		
To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examiner:	in: To the best of my kno On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation, in π	ny opinion, death o	ccurred at the time, da	ite and place, and due	to the cause(s)
To To Control	×	30. N. m. and address of person who color	eted cause of death (Item	23a) (Type,	Print) TO	0304	RRING 1	Pd. Date signed (Month)  EFTEMBE  nD	n, Day, Year) P. 7, 2006
S Regis	tate strar	31. Date filed (Month, Day, Year) SEP 1 2006	31 Registrar's Signa	ture	ULNE	y MD	20832		

06-06470 Emma Johnson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	- 6	1- For State Critificate of Death Registrar	Re	eg No	2006 3036
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)  EMMA JEAN JOHNSON	2. Date of Deal Month August 28	Day	Year 2114 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea		4c. Co	unty of Death
		Shady Grove Adventist Hospital Rockville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24h	rs 8 Date of Bir		tgomery  YYYY) 9. Birthplace (State or
Funeral Director	-	C. Good Good II, Manager	Oct.		
vlaryland 28a-f show any 1 at once.	5	10a. State MD 10b. County Montgomery 10c. City, Town or Location Gaithersburg			10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Dire	10e. Street and Number 30 Benji Court 10f. Zip Code 20877			of What Country? U.S.A.
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	/ Funeral	11. Marital Status 1			Race - American Indian, Black, White, etc.
natural	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life DO NOT use recognitions).		16b. Kind	of Business/Industry
136 hin 72 l e than "1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  10th Laundry Presser		Dr	y Cleaners
5-0036 iled within 72 Hygiene I other than the Medical		17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Middle, I		perwood
21215-0036 sold be filed within 7 Mental Hygiene marked other than it event, the Medica	To Be	19a Informant's Name/Relationship (Type Print )  19h Mailing Address (Street and Number of			_
e, MD 21215-00; I and 2 should be filed with Health and Mental Hygiene item 27 is marked other ti		Samantha Johnson (Daughter) 13050 Thyme Ct.,			
Baltimore, N permit. Pages I and Department of Healt Important: If item injury or other trau		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Population 5 Other Specify  21. Signature of Funeral Service Liverses  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Funeral Srv 9  21. Signature of Funeral Service Liverses	Date /10/06	Ale	xandria, VA
Baltii permit. Departm Imports		21. Signature of Funeral Service Life ise 22 Name and Address of Facility S  246 N. Washing			
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line  Immediate Cause (Final disease a. Narcotic Intoxication	c or respiratory arr	est, shock,	or heart Approximate In erval Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	iner	If any, leading to immediate Due to (or as a consequence of):			
ed ssit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, cate be executed physician and the burial - transi	Medical	X UNPENDED item#23a,27,28a-f,prME,g859,9/26/06	יויין		
		IF FEMALE: 23c. If yes, outcome of pregnancy			ate of delivery
Box 687 e death certific the attending p	sician	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	gnancy	Moi	nth Day Year
Bo the deat y the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use	contribute to the cause of death?
cords, P.O. B law requires that the de has been signed by the 2 should be detached	þ	Table Cities Grant Control Con	1 Ye	s 2 No	o 3 Probably 4 🗸 Unknown
rds, v requir s been s	etec		24a. Was autor	osy	24b. Were autopsy findings available prior to completion of cause of
Vital Records hysician: The law requi this certificate has been	Completed		perfo 1 ✓ Yes	rmed? 2 No	death? 1 Yes 2 No
ician: s certifi	Be	25. Was case referred to medical examiner?	rsing Home 5	Residence	6 Other:
n of V ing Phys After thi	T0	1 ✓ Yes 2 No This injury 2 € Trootspare 1 2 € Trootspare	28d Describe		
IVISION or Attendir after death. Director: A	atio	Natural 5 Pending Fnd 8/28/2006 Fnd 8:15 pm 1 Yes 2 X No Investigation	unknown		
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after death.  reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact	Certification:	3 Suicide 6 X Could not be determined (Specify) Sound at home.	or Town, S GAithers	State) 3()	Number or Rural Route Number, City  Benji Court  D
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cau	se(s) and m	
ESES	Me	29b. Signature and title of certifier 29c. License number			e signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)		Augusi	t 29, 2006
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 2120	1	
	ate				
Regis	ાલા	West Market -			

			For State Registrar		State of Ma	aryland / D	epartm <i>Certific</i>	nent of H Cate of L	lealth ar D <i>eath</i>	nd Men		iene2	006	30368
	Physici		Decedent's Name (F     MAX		OON KEELER,	JR.					Date of Deat Month PTEMBER	Day	Year	3. Time of Death 2:00 PM
>	/Medic Examin		4a. Facility Name (If no	t institution, give	street and number)		4b.	City, Town, or	Location of I				ounty of Deat	
			HOLY CROS						ER SPRI			MO	NTGOMER	
	Funeral Director		5. Social Security Number 110-24-671	5	7. Age	83	Yrs. Mor	Inder 1 Year oths Days	If Under 24 Hours	Min.	Date of Birth Month, Day, VEMBER		Co	thplace (State or Foreign buntry) LINOIS
	land ow		Usual Residence of De 10a. State 10	b. County		10c. City, Town	or Location	1						10d. Inside City Limits
	Mary I eho	to	MARYLAND	MONTGOMERY	Z		SIL	VER SPRI	NG					1 ☐ Yes 2√ No
	or 28e	Directo	10e. Street and Numbe	er .			10	f. Zip Code	-	·	10	og. Citizer	of What Co	ountry?
	ath wi		10600 SH	ADY CIRCLI					0903				U.S.A.	
36	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow the Macifical Exertative could be challfied at	by Funeral	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4 ☐		12. Was Decedent If Armed Forces?  1 ∑ Yes 2 ☐ N If Yes, Give Year or Dates:	lo.		ecedent of Hi specify Cubai es 2 No	ispanic Origir n, Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- in, etc.)		Race - Ame Black, White ecify:	e, etc.
2-0036	2 hou		15	. Decedent's Ed	ucation	1944-1947   16a.	Decedent's	Usual Occupa	ation			16b. Kind	of Business/	WHITE Industry
215	ithin 7. 18. 18. "n	Completed	(Specify of Elementary/Secondary)	only highest grad	College (1-4or 5	+)		Usual Occupa of work done d OT use retired,	during most o	of working				
	be filed within tal Hyglene. d other than event, the Ma		17. Father's Name (Firs	et Middle ( set)	4		MAN	AGER	19 Mother's	e Namo /Fi	rst, Middle, M	hidan Su	ATT	
Maryland 21		To Be			KEELER, SR.						HOONMAKI		mame)	
ary	should be and Menta is marked	F	19a. Informant's Name			19b.	Mailing Add	iress (Street a	and Number	or Rural Ro	ute Number,	City or To	own, State, 2	Zip Code)
	s 1 end 2 should if Health and Men item 27 is marke other traumatic		LOIS KE	ELER - WI	FE .		1000	ADY CIRC	LE, SIL		RING, M	ARYLAN	D 20903	3
Baltimore,	Pages 1 ment of Hu ant: If iter		20a. Method of Disposi 1 ☐ Burial 2 🗹 C 4 ☐ Donation 5 [	remation 3 🗆	Removal from State	1	y, crematory	(Name of or other place CREMATORY	. 1	Date 9/9/20			ion - City or	
Balt	permit. Pages Department of Importent: If I eny Injury or once.		21. Signature of Funer		. Klobe	A		ne and Addres O NEW HA			S-RINALI E, SILVI			OME, INC ARYLAND 20904
			23a. Part1. Enter the c shock, or heart fa	disease, or comp	lications that caused one cause on each lin	the death. Do n	ot enter the	mode of dying	g, such as ca	ardiac or res	spiratory arre	st,		Approximate Interval Between
N.	Physician		Immediate Cause (Fin disease or condition resulting in death)	al	a PNEUMONI.	A							3	Onset and Death
	/Medical Examiner		rosulting in Godiny		Due to (or as	a consequence o	of):							
		Jer	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or inju-	ions, diate	b. Due to (or as	a consequence o	of):							= 1 = = = = = = = = = = = = = = = = = =
	acuted ind transit	Examiner	Cause (Disease or inju that initiated events resulting in death) Last		с									
68760,	s be executed sicien and burial-transit	a Ex	1650iting in Ceatin, Case		Due to (or as	a consequence o	of):							
687	ificate g physi as the l	edical			d.									
P.O. Box	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/M	IF FEMALE:  23b. Was decedent prointhe past 12 mo  1  Yes 2 No  9  Unknown	nths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		pic pregnancy or (specify)				23d	. Date of deli Month	ivery Day Year
ds, P.	as the	2	Part II. Other significat		intributing to death bu		the underly	ing cause give	en in Part I.					the cause of death?
Vital Records,	e law require has been si je 2 should b	Completed									24a. Was an autopsy perform	/	4b. Were au prior to death?	ntopsy findings available completion of cause of
a	iclan: The la certificete has rector, page 2	e Co	25. Was case referred	to madical					00 PI		1 ☐ Yes 2	⊠ No	1 ☐ Yes	2 □ No
>	ysiclan: s certific director,	To Be	examiner?		Hospital: 1 🔀 Inpatie	nt 2 ER/Out	patient 3	7 DOA Othe			ne <i>ck only one</i> 5 □ Reside		Other (Spec	cify)
Division of	Attending Physiclan:  # death.  # death.  # the tuneral director, by the tuneral director, in the tuneral director.		27. Manner of Death	5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. T		28c. Injury Work			Describe ho			
SIO	uttendir death. ctor: Al y the tu	catlo	2 Accident	investigation			М	101	Yes 2 □ No					
$\leq$	after of Direction by	Certification;	4 Homicide	determined	28e. Place of Inju- building, etc		rm, street, fa	ctory, office			Location (Str City or Town		umber or Ru	iral Route Number,
	spitei nours neral / tilled		29a. Certifier 1(2	Certifying Phy	vsician: To the best of	of my knowledge,	, death occu	rred at the tim	ne, date and p	place, and	due to the ca	use(s) an	d manner as	stated.
	To the Hospitel or Attsndi within 24 hours after death To the Funeral Director: A completely tilled in by the to	edlcal	(Check only 2 one)	J Medicai Exam	iner: On the basis of and manner sta	examination and	Vor investig	ation, in my op	oinion, death	occurred a	t the time, da	te and pla	ice, and due	to the cause(s)
	Vith To 1	Σ	29b. Signature and title		a (.a.	0		29c. License						h, Day, Year)
)	8				a cras	1		D608	326			SEPTEM	BER 5,	2006
			30. Name and address KSHAMA GAR		ompleted cause of de 1500 FOREST			R SPRING	, MARYL	AND 20	910			
	Sta Registr		31. Date filed (Month, I			ar's Signature			-					
	negisti	al	35	1 11 (	TOUR THE PARTY AND INCH.	N 10	12/1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 13, 2006 Physician 10:31p Betty Gibbs Long /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Prince George's Fort Washington Hospital Fort Washington 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)
July 23,1926 Washington, DC If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 👺 F 80 Yrs. 579-30-2113 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State item 27 is marked other then "netural", or Items 23a or 28e-f show other treumstic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Accokeek 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 20607 USA 1108 Trunnel Lane Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Administrative Assistant I.B.E.W. Pages 1 and 2 should be filed announced to Health and Mental Hygiciant: If item 27 is marked other 1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gibbs Ethel Ε. Steele Carlos D. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30281 Gershwin Road, Charlotte Hall, MD 20622 Donald E. Long/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Importent: If ite ₩₩Burial 2 ☐ Cremation 3 ☐ Removal from State 9/19/2006 Cheltenham, Maryland Maryland Veterans 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee W. Box 128 Charlotte Hall once FUNELPI Echols 50 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or as a consequence of) use as the burial-Box 68760. physician certificate be Physiclan/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No
9 Unknown Month Year ţ 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has page 2 ector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours atter death To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 Old Line Center, Waldorf, MD 20602 Dr. Louis V. Kaufman 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

SEP 1 5 2006

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year Physician LAM PUT LT SEPTEMBER 06, 2006 3:55 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 □ F Yrs. Director 212-33-1451 81 APRIL 20, 1925 VIETNAM Usual Residence of Decedent the Maryland 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits r Iteme 23a or 28a-f show singrapust be notified at 1 ☐ Yes 2 X No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 WHITESTONE ROAD 20901 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural, or Item any injury-crother traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced ASTAN Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 CLERK PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDGAR LI - SON 209 WHITESTONE ROAD, SILVER SPRING, MARYLAND 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 9/12/2006 SILVER SPRING, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 20a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ACUTE PNEUMONIA /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list or officers, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit CANCER OF THE PROSTATE attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ page 2 should be ATHEROSCLEROSIS 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has performed 2 🖾 No 1 ☐ Yes 1 Yes 2 🗌 No Hospitel or Attending Physicien: After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No this 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending М hours after death. investigation 1 Yes 2 No 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours af To the Funeral D 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medica npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27865 SEPTEMBER 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK LI, M.D., 1721 UNIVERSITY BLVD. W., WHEATON, MARYLAND 20902 31. Date filed (Month, Day, Year) gegistrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) September Day 3:25P **Physician** 2006 Miller Blanche /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Nursing & Rehab. Center Carroll Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | Dec . 25, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2X F Maryland 94 220-16-1327 Director Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Mudical Examinar rules by molified at 1 Yes 2 No Directo Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1234 Washington Rd. 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No Il Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐KNo Specify: Specify: ģ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) sewing factory seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Steinberg Sr. Barbara Elizabeth Kohles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health an ant: If item 27 is r Ruth Franklin/ pers. rep. 123 Main St. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Dep rtment of Important: If any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery 9/13/2006 nr. New Windsor, MD 21. Signature of Juneral Service croen 22. Name and Address of Facility Hartzler Funeral Home 07 Jares 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that are sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 ☐ Yes or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed Month, Day, Year) 29b. Signature and title of certifier WIL nd address of person who completed cause of death (Item 23a) (Type, Print) 3 Westminster, ohn W. Middleton

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) 2006

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		•	1 - For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artmer <i>rtific</i> at	te of D	aith ar <i>eath</i>	па ме		ene Z g. No.	006	30372
I	Physici /Medic		Decedent's Name (First, Middle, Last)     MELVIN A. MOSK	COWITZ						Date of Death Month SEPTEMBER	Day 09, 2	Year 2006	3. Time of Death  3:30 AM
	Examin		4a. Facility Name (If not institution, give s	treet and number)			Town, or Lo	ocation of [	Death			nty of Death	
	Funeral Director		7624 WHEATCROFT COURT  5. Social Security Number  6. Sex 124	7. Age (In y	rs. last birthday 71 Yrs.			If Under 24 Hours	Min.	Date of Birth (Month, Day, 1	(ear)	9. Birthple Count NEW YO	ace (State or Foreign try) RK
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c	City, Town or L	ocation						10	d. Inside City Limits
	Maryis	Ď	MARYLAND MONTGOMERY		ETHESDA								1 ☐Yes 2 🛣 No
	r 28a	Director	10e. Street and Number		JIIII DDII	10f. Zi	p Code			109	g. Citizen	of What Count	iry?
	23a c		7624 WHEATCROFT COURT				20817					S.A.	
36	s 1 end 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Mudical Exercities round be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 ☼ Married  3 □ Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever in Armed Forces?</li> <li>1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 19!</li> </ol>		Was Dece If Yes, spe 1 \( \text{Yes} \)		anic Origin Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- can, etc.)		Race - America Black, White, e cify: WHIT	etc.
9	72 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usu	al Occupation	on	of working	16	6b. Kind of	f Business/Ind	
Maryland 21215-0036	d within 7 giene. ir than *n the Med	Completed	(Specify only highest grade	College (1-4or 5+) 5+	EXECU:	DO NOT L	ork done dur ise retired)	ang most o	or working		OIL		
B	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Last)						s Name (F	irst, Middle, Ma		•	
<u> </u>	2 should be and Mental is marked (aumatic ev	2	LOUIS MOS  19a. Informant's Name/Relationship (Type	SKOWITZ	19h Mail	ina Addres		HELEN	or Pural F	Route Number, (		SKOWITZ	Code
	end 2 sl lealth an m 27 is r her traur		SALLY MOSKOWITZ/WIFE	e, Finty						DA, MARYL			C00e)
ore,	permit. Pages 1 er Department of Hea Important: if Item any injury or other once.	- 0	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	201	p. Place of Disp cemetery, cre				Date			on - City or Tov	wn, State
Ĕ	Pages Iment of I Iant: if Ito Jury or o		4 Donation 5 Other (Specify)	SINOVALINOIN STATE	JUDEAN MEI	MORIAL	GARDEN	S 09	/11/2		NEY, M	MARYLAND	
Baltimore,	permit. Departm imports any inju		21. Signature of Funeral Service License	Pudewig						E, INC. E, SILVER	SPRIN	G, MARYI	LAND 20904
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ath. Do not en	iter the mo	de of dying,	such as ca	ardiac or r	espiratory arres	t,	ì	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a cons									
	Examiner		Sequentially list conditions b.										
	ed sit	Examiner	Sequentially list conditions, a vicause. Enter Underlying Cause (Disease or injury	Due to [or as a cons	equence of								
<u>~</u>	ificate be executed g physicien and as the burial-transit	Exan	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):								
68760	ate be nysicie he bur	edical	d.										
_	= C3 m	/Med	IF FEMALE:	3c. If yes, outcome of pre	anancy						1	D	
P.O. Box	The law requires that the death certif sie hes been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic p □ Other (s						Date of deliver Month	ry Day Year
	signed by	Ď	Part II. Other significant conditions con	tributing to death but not	resulting in the (	underlying	cause given	in Part I.					e cause of death?
ço	w requir s been si should	iete								24a. Was an	24	b. Were autop	sy findings available
_ 		Completed					·		_	autopsy performe 1 ☐ Yes 2		prior to corr death? 1 \( \sum \text{Yes} \) :	npletion of cause of 2□ No
/ita	iding Physicien: Th th. : After this certificete funeral director, pag	BeC	25. Was case referred to medical examiner?				<del></del>		of Death (C	Check only one			
5	Attending Physicien: r death. sctor: After this certification the funeral director.	2	1 Yes 2 No  27. Manner of Death	ospital: 1 ☐ Inpatient 2				4 LINUIS		5 🖾 Residen			)
0	th: After	ation	1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	) Injury	м	28c. Injury a Work? 1 □ Ye	s 2∐No			injury coo	Jun 04	
Division of Vital Records,		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, si	treet, factor	y, office		281	Location (Stre City or Town,		mber or Rural	Route Number,
	To the Hospitei or Attentwithin 24 hours after deation 4. To the Funeral Director: completely filled in by the	Medicai C	29a. Certifier 1 Certifying Phys	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, dea sination and/or in	th occurred nvestigation	at the time, n, in my opin	, date and p nion, death	place, and occurred	d due to the cau at the time, dat	se(s) and e and plac	manner as sta ee, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License n	number		290	d. Date sig	ned (Month, E	Day, Year)
)	15		> Kelleri diran	illa MD		1	10 21	1025	•		9-10	-2006	5
		29	30. Name and address of person who con				NCTON	DC 200	007				
	Sta	te	ROBERT WARREN, M.D., 38 31. Date filed (Month, Day, Year)	32 Registrar's Si	onature			DC 200	10 /				
	Poniete		SEP 1 1 200	TE I PA	M MA	ask)							

			1 - For State Registrar	State of	Marylar	•	artmer rtificat			ind M	ental Hyg	iene g. No. 20	106	3037
ı	Physici		Decedent's Name (First, Middle, Las     MARGARET JANE								2. Date of Deat Month SEPTEMBER	Day	Year	3. Time of Death 8:00 A M
	/Medio		4a. Facility Name (If not institution, give		ber)		4b. City,	Town, or	Location o	f Death	SEI TEMEI	4c. County		
			12710 LAURIE DI						ER SPRI			1	TGOME	RY
b	Funeral Director		5. Social Security Number 6. Se 578-64-1865	x □M 2\\ F   7	70 Age (In yrs.	last birthday) Yrs.	Months Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, JANUARY 1		9. Birthp Court ENGL	
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1	0d. Inside City Limits
	Mary F-f sh	tor	MARYLAND MONTGOME	RY		SI	LVER S	PRING						1 ☐ Yes 2X No
	th the	Director	10e. Street and Number		-		10f. Zip	Code			11	g. Citizen of V	Vhat Coun	itry?
	ath wi		12710 LAURIE DI	RIVE				2090				UNITE	D KING	DOM
39	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "naturel", or Items 23e or 28e-f show event, Ite Mydleal Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? [X] No		Was Dece If Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		e - Americ ck, White,	
21215-0036	72 hou	ted	15. Decedent's Edi			16a. Dece				of working		16b. Kind of Bu		
21	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT u	se retired,	luring most )	or workir	ng			
2	filed w Hygien sther th	Cor		5+			JEWE	LER	10 11 1				EY JEW	ELERS
and	uld be fill dental H rked ott	Be	17. Father's Name (First, Middle, Last)								(First, Middle, A	faiden Suman	10)	
Maryland	s 1 and 2 should be f Health and Mental ftem 27 is marked other traumatic ev	은	FRANK CLEVELAND  19a. Informant's Name/Relationship (T	vne Print)		19h Mailir	no Address	(Street			ET HALL  I Route Number,	City or Town	State 7in	Codel
<u>S</u>	and 2 s ealth an n 27 is i		IASONE MONTILLO - DAU		. <b>A</b> W						PRING, MA			C009)
ē,	ges 1 ar t of Hea if item or other		20a. Method of Disposition	SHILD IN	20b. I	Place of Dispo cemetery, crei	sition (Na	me of				Oc. Location -		wn, State
more,	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		tate	RT LINCOL	-	•	1	9/9/2	006	BRENTWOO:	D MAR	VI AND
<b>a</b>	permit. Page Department Important: If any Injury or once.		21. Signature of Funeral Service Licens						s of Facility		ES-RINALD		-	
m)	88 5 8		Mydin Ti	Klobe	1	_   1	L1800 I	NEW HA	MPSHIR					YLAND 20904
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. ESOPHA Due to (o	AGEAL CA	NCER quence of):	er the mod	e or ayınç	g, such as o	cardiac o	respiratory arre	St,		Approximate Interval Between Onset and Death 1 YEAR
Box 68760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Exar	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d23c. If yes, outco	th 2 🗍 Feta	ancy	□Ectopic p					23d. Dat	e of delive	ry Day Year
<u>o</u>	at the de by the a tached f	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4∐Pregna 9□Unknov	nt at time of o vn	death 5∟	Other (sp	pecify)						,
ds, P.	juires that i n signed by lid be deta	þ	Part II. Other significant conditions co	ntributing to dea	th but not res	sulting in the u	nderlying o	ause give	ın in Part I.					e cause of death?
l Records,		Completed						-			24a. Was ar autopsy perform 1 Yes 2	ed?	Vere autoporior to con leath?	osy findings available npletion of cause of 2 No
/ita	Physician: ] r this certifical ral director, p	Be	25. Was case referred to medical examiner?					Ta.		of Death	Check only one	ý .		
5	Phys this al dii	P	1 163 2 X 140			ER/Outpatier			4 LI NUI		ne 5 🛛 Reside			')
n N	ing Afte une	io io	27. Manner of Death 1 □XNatural 5 □ Pending	28a. Date of (Month	Day Year)	28b. Time of Injury		8c. Injury Work			8d. Describe ho	w injury occurr	ed	
	or Attender fler deat Sirector: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	f Injury - At h g, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factor		/es 2□N		18f. Location (Str City or Town		er or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funerel t completely filled	Medical C	29a. Certifier (Cneck only one)  1 X Certifying Phy 2 Medical Exam	rsician: To the b iner: On the bas and manne	is of examina	owledge, death	n occurred vestigation	at the tim	e, date and inion, deat	d place, a h occurre	and due to the ca	use(s) and ma te and place, a	nner as st and due to	ated. the cause(s)
	To the To the Comp	Ř	29b. Signature and title of certifier	$\cap$				c. License		-	1	d. Date signed		
	5		1 Setelle	4n				045	1014		S	PTEMBO	W T	7/2006
	_		30. Name and address of person who c											
			ISABELLA MARTIRE, M.	7			UREL,	MARYL	AND 20	707				
	Sta Registr		SEP 1 1 20	006	gistrar's Signa	M. So	with							

			1 - For State Registrar	State of Mary					giene Reg. No. 20	06	30374
					MANLEY			Month	Day	Year 2006	3. Time of Death 12, 05 PM
0					PANELI	4b. City, Town, or	Location of Death		4c. County		(A) 0 0 /
								To Bay y Bid		E GEO	
6	Funeral Director			1 M 207 F		Months Days	Hours Min.	(Month, Da	y, Year)	Country	ce (State or Foreign y) YLAND
9	pu &		Usual Residence of Decedent			ecation			, , , , ,		d. Inside City Limits
-	Maryla f ehor	to			-					100	1 XYes 2 No
>	h the	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Countr	y?
Physician Medical Examiner  Physician Medical Examiner  To CTORS COMMUNITY HOSPITAL  S. Social Security Number (If not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. Social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. As a social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. As a social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. As a social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. As a social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. As a social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. As a social Security Number (In not institution, give street and number)  DO CTORS COMMUNITY HOSPITAL  S. As a social Security Number (In not in			U.S								
2,	ter de	Fune		Armed Forces?	r in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - Americar k, White, et	
77	ours a	by		If Yes, Give Year or Dates:		1□Yes 2□XNo	Specify:		Specify	" WHI	TE
1	n 72 h	letec			(Give	kind of work done of	luring most of work	cing .	16b. Kind of Bu	isiness/Indu	stry
7	d withi	omo		College (1-4or 5+)				W Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	BLACKIS	TONE :	FLORIST
1	be file d othe	Be	17. Father's Name (First, Middle, L				18. Mother's Nam	e (First, Middle,	Maiden Suman	10)	
×.	hould Men marks	7	7		19h Mailir	on Address (Street a			ENG		ode)
d:	nd 2 salth an 27 ion										,000)
7	T of He a		20a. Method of Disposition	2	20b. Place of Dispo	sition (Name of			20c. Location -		n, State
_ટે.	t. Pag rtment rtant:		4 Donation 5 Other (Sp.	ecify)	CRESTLAW	N MEM. GA	RDENS 9-1	11-2006	MARRIOT	TSVILI	LE, MD.
Z	Depariment impos		21. Signature of Funeral Service 12	. // . /2	M00091 CI	HAMBERS F CLEVE	is of Facility UNERAL H( LAND AVE.	OME & CF	REMATORI	UM,P.A	A. 737
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused the	death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,	A	Approximate nterval Between
			disease or condition	a CARDIC	PULM	ONARY	ARR	EST			Onset and Death
	D H	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):						
	xecute send	xam	that initiated events								
,	te be e ysician	calE		O. CHRON	IC OB	STRUC	TIVE T	PULMON	ARY DU	S'EASE	
(	entificating physe as the	Medi	IF FEMALE:								
C	eath ce ettend for us	clan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3				23d. Dat Mo	e of delivery oth D	r Pay Year
	. 0 00	hysi	1 ☐ Yes 2 PNo 9 ☐ Unknown								
į	res tha signed be de		Part II. Other significant condition	s contributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.				V
	v requi	eted	CONGESTIV	L HCAKI	1/31(	-OKC		1		3 Probab	
ć	The lay te has age 2	omp						autop	rmed*	rior to comp leath?	sy findings available betion of cause of
1	ital sian: '	0	25. Was case referred to medical examiner?				26. Place of Deat	1	-	☐ Yes 2	LINO
	Physic this ca	2	1 ☐ Yes 2 No	1 Dinpatient		I 3 DOA	4   Nursing no				
1	nding Ith. : After e tuner	ation	1 Natural 5 ☐ Pending	(Month, Day Ye	par) Injury	Work		2dd. Describe i	low injury occurr	90	
	r Atter ler dea irector	tlfice	3 ☐ Suicide 6 ☐ Could no	ed 286. Place of Injury	- At home, farm, stri	eet, factory, office				er or Rural F	Route Number,
C	pital o		20a Cartifiar 10 Cartifuing	Physician: To the best of m	ur kasuladas, dasth	a construction of the first					
	ne Hos ne Fun detely	edica	(Check only 2 Medical E	xaminer: On the basis of exa	amination and/or inv	vestigation, in my op	sinion, death occur	red at the time,	cause(s) and ma date and place, a	nner as stat and due to th	he cause(s)
	within To th	Ž	29b. Signature and title of certifier	1- 100-		29c. License		7	29d. Date signed	(Month, Da	ay, Year)
	4		20 Name and address of access		(ltom 22=) /T	Drint)	01220	~	Dept	. 07	2006
			30. Name and address of person w	O 1 9	(nem 23a) (1ype,	enny	21 1.	V 1. 100	100	()	7
			Kevin art	an ollo	Signature	-UCICK	d, No	inna	m, in	1), 0	20106

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32 Registrar's Signature

Carpenter

1

Brian

31. Date filed (Month, Day, Year)

DI04502

9901 Medical Center Dr Rockville, MO 20810

	1 - For State Registrar	State of Maryland	d / Department of H Certificate of I	lealth and M Death		giene Reg. No. 200	16 30376
Physician /Medical	Decedent's Name (First, Middle, La	LOUIS	MACKII	7	2. Date of Dea Month Sept.		3. Time of Death
Examiner	4a. Facility Name (If not institution, given the sapea)	ke Medical C	enter Be	Location of Death			Harford
Funeral Director		Sex 7. Age (In yrs. Ia	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 1/15/	Year) 1931	Birthplace (State or Foreign Country) Maryland
with the Maryland a or 28a-f ehow the notified at Director	10a. State 10b. County MD. Har	ford 10c. City,	Town or Location	arrettsv	rille		10d. Inside City Limits 1 ☐ Yes 2 💆 No
with the s or 28	10e. Street and Number		10f. Zip Code	07.00/		10g. Citizen of Wha	•
36 36 s after death with the Mar or iteme 23a or 28a-1 e arritrat mast be noutled y Funeral Director	3413 North F  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 □ No If Yes, Give	If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
15-003 n 72 hours a nulcal Eva	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr	Year or Dates: NOT	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation	ng	16b. Kind of Busine	White ess/Industry
d 21215-0 d 21215-0 tilled within 72 ho ther than 'naturn ont, the Mudical	Elementary/Secondary (0-12)	College (1-4or 5+)	Electrical	Enginee	r		nghouse
De first H de out	17. Father's Name (First, Middle, Las.  Joseph		Mackin	18. Mother's Name	hy		(unknown)
Maryla and 2 should ben n 27 le marke er traumatic	19a. Informant's Name/Relationship Denise L. Mack	in/Wife	19b. Mailing Address (Street a 3413 N. Furr	nace Rd.			te, Zip Code) 21084 lle, Md.
More more sent of H	20a. Method of Disposition  1	Dulaney	ace of Disposition (Name of metery, crematory or other place Valley Mem (22. Name and Address	ar 9/23			m, Maryland
Baltii. Dermit. Departm Importan any inju	M. Blacket	en Koof	E.G. Ku	irtz & S	on Fur	eral Ho	Maryland ome, P.A.
Physician /Medical	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. Acute L	Do not enter the mode of dying Injury	g, such as cardiac c	or respiratory ari	est,	Approximate Interval Between Onset and Death
760, te be executed with the second of the executed by the executed of the exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the total	Sal Isch	emia Ism R	epair	-	
Li S M O. Box 68 ne death certifica the attending pl hed for use as t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal ( 4 ☐ Pregnant at time of decent of the control of th	death 3 □Ectopic pregnancy			23d. Date of Month	delivery Day Year
rds, P. crds, P. quires that the n signed by aid be detacted by Phy	Part II. Other significant conditions Chronic Obstru	1, 0,1	ting in the underlying cause give				e to the cause of death?  Probably 4 Unknown
(Ital Records, class: The law requires the artificate has been signed and control, page 2 should be a Be Completed by	Coronary Art	ery Diseas-			24a. Was a autops perfor	sy prior	
- N = 0 E -	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E	R/Outpatient 3□ DOA Othe	26. Place of Death	(Check only or	ne)	
On O On O On O ding Ph h. After th funeral	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Work			ence 6 ⊡Other (S ow injury occurred	оресіту)
Division of Division of State death.  To all Director: After I led in by the funers  Certification;	3 ☐ Suicide 6 ☐ Could not be determined		ne, farm, street, factory, office		28f. Location (S City or Town	treet and Number of n, State)	r Rural Route Number,
Division Division to the Hospital or Attention 24 hours after deat. To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)  Certifying Place 2 Medical Example 2	nysician: To the best of my know miner: On the basis of examination and manner stated.	ledge, death occurred at the timon and/or investigation, in my op	ne, date and place, a pinion, death occurre	and due to the c ed at the time, d	ause(s) and manner ate and place, and	r as stated. due to the cause(s)
To trois	29b. Signature and title of certifier	. ~o	29c. License	4781	2	9d. Date signed (M	onth, Day, Year)
5	30. Name and address of person who	completed cause of death (Item:		Prive	Ral	Air mi	7 21014
State Registrar	31. Date filed (Month, Day, Year) SFP 2 5	32. Regultar's Signatu			Der	THILL.	JOIL TO

			1 - For State Registrar		State of M	laryla		artmen rtificat			nd M		Reg. No 20	06	30	377
¥	Physic	ian	Decedent's Name (Fi  Virgil	rst, Middle, Last) D.		N	icKenzi	_		Sr.		2. Date of Dea	ath Pay	Year		of Death
	/Medi Examir		4a. Facility Name (If not				ICINETIZI		Town, or	Location of	f Death	09-	4c. County		10.0	JJ/1"
		â	929 Maryla						nberl				Allega	any		
y.	Funeral Director	100	5. Social Security Numb 217-14-483 Usual Residence of Dec	39 <sup>1</sup> ×	7. A	ge (In yrs 84	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt Month Day Jan 19	, 1922	9. Birth	place (State	e or Foreign
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tema 23a or 28a-1 show ther, the Medical Exarchinar roust be notified at		10a. State 10i	o. County		10c. C	ity, Town or Lo		. d						10d. Inside	City Limits
	he Ma 28a-f	Completed by Funeral Director	MD	Allegan	y 		Cum									es 2□No
	and the r	Ö	10e. Street and Number 929 Maryla		ue.			10f. Zip		21502			10g. Citizen of	What Cou SA	ntry?	
	death	nera	11. Marital Status		12. Was Decedent Armed Forces		J.S. 13.	Was Deced				cify Yes or No- Rican, etc.)	14. Rac	ce - Ameri	can Indian,	
36	s after	y Fu	1 Never Married		1 √ Yes 2 ☐ If Yes, Give	No	1		2 No	Specify:	r delto i	ricall, etc.)		<sup>y:</sup> white,		
9-9	2 hour	ted t	15.	Decedent's Edu		ww	16a. Deced	dent's Usua	al Occupa	ation			16b. Kind of B			
21215-0036	ithin 7 a. nan "n	npie	(Specify o	nly highest grade y (0-12)	e completed) College (1-4or	5+)				luring most )	of workir					
d 21	filed withi Hygiene. other than	e Cor	17. Father's Name (First	. Middle. Last)			Shippi	ng De	ept.	18 Mother	's Name		Tire Cor		У	
Maryland	Mental Mental arked o	To Be	Galltziar	L. McKe						Hele	n M	arie Gol	dsworth	y Mc	Kenzi	е
	1 and 2 sho Health and Iem 27 Is m		19a. Informant's Name/ Mary Shad		pe, Print) daug	hter	19b. Mailir 929	Maryl	and .	Avenu	or Rura. 1 <b>C</b>	Cumb	r, City or Town, erland	State, Zi	MD 2	1502
Baltimore,	8 = 5		20a. Method of Dispositi 1 Burial 2 Cr 4 Donation 5	emation 3 R	emoval from State		Place of Dispo cemetery, cren Peter &	natory or o	ther place	ery		ate 9/22/2006	20c. Location -	-		MD
Balti	permit. Pa Departmen Important: any injury		21. Signature of Funera		hle	U	. 22	Name an	d Address arpelli	Funer	al Ho	me, P.A.	and, MD	24502		
2			23a. Fart1 Enter the di shock, or heart fail	sease, or compli	cations that cause	d the dea	th. Do not ente	er the mode	e of dying	g, such as c	ardiaç oi	spiratory ari	est,	21302	Approxim	ate
	Physician		Immediate Cause (Fina disease or condition		Meta	sta	tie (	are	ino	ma	el.	Pros 6	h-		Onset an	
	/Medical Examiner		resulting in death)		Due to (or as	a conse	quence of):								1	
5		Jer	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurial)	ons, b	Due to (or as	a consec	quence of):								<del></del>	
	ecuted and transit	Examiner	Cause (Disease or injur that initiated events resulting in death) Last	7 1												
8760,	ate be executed hysician and the burial-transit		receiving in death, and		Due to (or as	a conse	quence or);									
687	ificate ig phys as the	edic														
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and as should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:  23b. Was decedent predict the past 12 mon 1 Yes 2 No 9 Unknown	ths?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	aldeath 3□	Ectopic pro Other (sp					23d. Da Mo	te of delive	ery Day	Year
٩.	res that II igned by be detac		Part II. Other significan	t conditions con	tributing to death t	out not res	sulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use cont	ribute to the	ne cause of	f death?
rds	w requires been sign should be	ed by						_				1 □ Y	es 2□No	3 Prob	ably 4	Unknown
m m	The ate h	Completed	-									24a. Was a autops perform	ned?	Were auto prior to co death?	mpletion of	s available cause of
/ita	Physician: T this certificat ral director, pa	Be	25. Was case referred to examiner?	1					Tou		of Death	Check only or				
o	Physic rthis ral dir	2	1 ☐ Yes 2 ☐ ♣ →	П	ospital: 1 ☐ Inpati 28a. Date of Inju		ER/Outpatien 28b. Time of			4 🗀 Nurs			ence 6 Oth		v)	
ion	Attending I r death. ector: After by the funer	atior	1- Natural 5   2 ☐ Accident	Pending investigation	(Month, Da	y Year)	Injury	М	8c. Injury Work 1 🔲 Y	?` ′es 2 ∐ N			on many occur.	00		
É	al or Atte s after des il Directo ed in by th	Certification:	3 ☐ Suicide 6   4 ☐ Homicide	Could not be determined	28e. Place of In building, e	jury - At h tc. <i>(Speci</i>	ome, farm, stre	eet, factory	, office		2	8f. Location (Si City or Town	reet and Numb n, State)	er or Rura	l Route Nu	mber,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical (	29a. Certifier 12 (Check only one)	Certifying Phys	sicien: To the best ner: On the basis of and manner st	it examina	owledge, death ation and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, death	place, a	nd due to the c d at the time, d	ause(s) and ma ate and place,	inner as s and due to	ated. the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title	acontifier	0			29c.	. License				9d. Date signe	d (Month,	Day, Year)	
	~			1	7km				1) (	1033	280		Sept	19 3	2006	>
6	, !		30. Name and address of		mpleted cause of o	death (Iter	Seedin Aug			- 0		damed \$ 45	24500	,		
	Sta		Sunil Gue 31. Date filed (Month, D	ta M.D.	32. Progisti	ar's Sign	atura	eni A		ie Cur	noer	iand ML	21502			-
	Registr	ar	CE.	D 9 5 200	16 8	121	S ST	A Same								

Physic	ian	1. Decedent's Name (First, M.	iddle, Last)								2. Date of D _ Month	eath Da	y Yea		. Time of Deal
/Medi		Gene		tings		hillip					Septem		7 20		700
Exami	ner	4a. Facility Name (If not institu				100	4b. City	, Town, o	r Location	of Death	·	40	. County of D		
		5. Social Security Number	6. Sex	MEDICA		. last birthday	ıl If Unde	r 1 Year	If Under	r 24 Hrs.	8 Date of B	irth			(State or For
Funeral Director		222-05-1580	1 🔏	M 2□F	88	Yrs.	Months		Hours	Min.	8. Date of B (Month, D 6/18/	ay, Year)	3 M	Country) laryl	(State or For
land ow		Usual Residence of Decedent 10a. State 10b. Cou			10c. C	ity, Town or L	ocation							10d.	Inside City Lir
a-f eh	ctor	Maryland Wi	comic	0		Salis	bury								<b>X</b> ☐Yes 2☐
death with the Maryland me 23a or 28a-f ehow Froust be notified at	Funeral Director	10e. Street and Number 8435 Hilda	Drive					p Cod# 21804	4			1	tizen of What USA	Country	?
	nera	11, Marital Status	1	2. Was Dece Armed Fo	edent Ever in	U.S. 13	Was Dece	dent of F	lispanic O	rigin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - A		Indian,
within 72 hours after desene. then "natural", or iteme	by Fu	1 ☐ Never Married 2 ☐ M 3 M Widowed 4 ☐ Divor		1 A Yes If Yes, Giv Year or Da	2 □ No e Arn		1 ☐ Y <i>e</i> s		Specify		rican, etc.)		Black, W	vhite	9
ithin 72 hours affile.		15. Dece (Specify only his	dent's Educ ghest grade	ation completed)		/Giv	edent's Usi e kind of w	ork done	durina mo	st of work	ing	16b. K	ind of Busine	ss/Indus1	ry
d within giene. er then	Completed	Elementary/Secondary (0-1	2)	College (1	-4or 5+)		oo NOT	ise retire	d)			S	ales		
tal Hy d oth	To Be C	17. Father's Name (First, Midd Edwin Philli				,					e (First, Middle de Benr		Sumame)		
DEN 5	F	19a. Informant's Name/Relati Margaret Whit				19b. Mai 728	ling Addres B3 Ma	s (Street in Si	and Numb	ber or Rura Villa	al Route Numi	ber, City (	or Town, State	a, Zip Co	de)
permit. Pages 1 end Department of Health Importent: If Item 27 eny Injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	on 3 □Re	emoval from	20b. State M	Place of Disp cemetery, cre 1COM1C	position (Na ematory or	me of other plac	<b>(θ)</b>		Date		ocation - City		
oermit. Pages 1 e Department of Her mportent: If item eny Injury or othe		4 □Donation 5 □Othe	r (Specify)		7	Park				9/9/(   <u> </u>   <u> </u>	ome Pr		isbury		
permit. Departimport eny inj		kinga.	100	16			501 3	now	Hill	Rd.,	Salis	bury	, MD 2	1804	JCIALIC
Physician		23a. Party. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition	, or complic List only on	cations that c e cause on e		Renal			ng, such a	s cardiac o	or respiratory	arr <i>e</i> st,		Int	proximate erval Betweer iset and Death
/Medical Examiner		resulting in death)		Due to (	(or as a conse	equence of):	1000	011-			-				4 - 48
	<u></u>	Sequentially list conditions,	b.		or as a conse	Sep 15								2	4 40
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>⊀</b>		(	.,									
ate be executed hysicien and he buriat-transit	Ical Exa	resulting in death) Last	d.	Due to (	or as a conse	equence of):									
ntificating physics as the		IF FEMALE:													
The law requires that the death certificate has been signed by the ettending phage 2 should be detached for use as the	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23	1□Live b	come of pregi wirth 2 Fe ant at time of own	tal death 3	□Ectopic ; □ Other (s		у				23d. Date of o Month	delivery Day	y Year
ires that the signed by dipe detact	d by Ph	Part II. Other significant con	ditions conf	tributing to de	eath but not re	sulting in the	underlying	cause giv	en in Part	1.	1	tobacco	use contribute	to the c	/
he law require e has been si	pietec		250 2								24a. Wa	s an	24b. Were	autopsy o comple	findings availation of cause
: The li											peri 1 Yes	ormed2 2/2 No	death	? es 2□	
ysician: Th is certificate director, pag	Be	25. Was case referred to med examiner?		ospital:	,			OA Oth			Check only				
	on: To	1 ☐ Yes 2 No  27. Manner of Death  Natural 5 ☐ Pe	-		npatient 2 ( of Injury th, Day Year)	ER/Outpatie 28b. Time tnjury		OA 28c. Injur Wor	4 🗆 1		me 5 ☐ Res 28d. Describe			pecify)	
ne Hospital or Attending Physician: 124 hours after death. 15 Funerel Director: After this certification in by the funeral director.	Certification:	2 Accident inv	estigation uld not be ermined	28e. Ptace	of Injury - At	home, farm, s	M treet, facto		Yes 2	]No	28f. Location City or To		nd Number or	Rural Ro	oute Number,
spital or ours afte nerel Dir filled in					ng, etc. (Spec										
• Hosp 24 hou • Fune ietely fil	edical	29a. Certifier 1 Garti (Check only 2 Medi one)	fying Phys cal Examin	i <b>er:</b> On the ba	best of my ki asis of examin ner stated.	nation and/or i	nvestigatio	at the til n, in my c	ma, date a opinion, de	ath occurr	and dua to the red at the time	date an	) and intermed diplace, and c	at state lue to the	d. cause(s)
To the comp	₹ S	29b. Signature and little of cer	tifjer)				29	c. Licens	se number			29d. Da	te signed (Mo	onth, Day	, Year)
-0/		▶ Stept	1t-	m	0			DI	1172	1		0	9/07/	06	
Da		30. Name and address of per	,												

State of Maryland / Department of Health and Mental Hygiene 200630379 For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September **Physician** 2251M Helen Jane Powers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) ADITL 17, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Country) 89Yrs. Director 214-76-3151 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any njury or other traumatic event, it a Marical Exertinal be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9715 Fernwood Lane 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ္ရ Clarence Franklin Blenard Dollie Mae Dietrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9715 Fernwood Lane Hagerstown, MD 21740 <u>Bonita J. Brannon/Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 09/18/06 Ha erstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between neet and Dea Immediate Cause (Final disease or condition resulting in death) sulumous Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a 1 Crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai To the I 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print AN 116 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of	Maryland / De	partment of h ertificate of	Health and Death	Mental Hyg	iene g. No. 2 (	006	303	380
	Physici /Medi		Decedent's Name (First, Middle,     ROY WILLIAM RAFT					2. Date of Deat Month SEPTEMBI	h Day	<sub>Үөаг</sub>	3. Time of E	)eath M
)	Examir		4a. Facility Name (If not institution,  ANNE ARUNDEL MED	ICAL CENT	ER	ANNAPOL			4c. County	ARUND		
ŀ	Funeral Director		5. Social Security Number  219–14–8486  Usual Residence of Decedent	5. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. last birthda 81 Yrs.	Months Days	If Under 24 Hrs Hours Min.			9. Birthpi Coun MARY		Foreign
taryland z i z i 5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 le marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Madical Expressional percentified at	To Be Completed by Funeral Director	10a. State 10b. County  MD QUEEN A  10e. Street and Number  1706 BAYSIDE DRI  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify only highest Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, L.  MARSHALL RAFTER  19a. Informant's Name/Relationshi	12. Was Deceder Armed Ford 1 XYes, Give Year or Da  Education grade completed)  College (1-	20 No 1943- les: 1946   16a. Dec (Griffe (Griffe 10f. Zip Code  21619  3. Was Decedent of If Yes, specify Cub 1 Yes 2 No  Dedent's Usual Occup ve kind of work done b. DO NOT use retire  CE SUPERIN	an, Mexican, Puer Specify: pation during most of wo d! TTENDENT 18. Mother's Nai	Specify Yes or Noto Rican, etc.)  rking  me (First, Middle, M.  LA LEWIS	Specifi Specif	What Coun  ce America ck, White, c  y: WHI  susiness/Inc  OF	an Indian, etc.  TE dustry  NATURA	2 <b>X</b> No	
,00,	cate be executed XI with the cate be executed XI with the category of the cate	dicai Examiner	JOAN RAFTER SP  20a. Method of Disposition  1 Rurial 2 Cremation  4 Donation 5 Other (Special Section 2)  21. Signature of Figure 1  23a. Part 1. Enter the disease, or conditions, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, or any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	consee complications make can be one cause on ear a. Due to (o b. Due to (o c.	20b. Place of Discemetery, ci	5 BAYSIDE position (Name of rematory or other plan VILLE CEME 22. Name and Addre FELLOWS, H LO6 SHAMRO mater the mode of dyir	TERY 09/ SS of Facility ELFENBEL CK RD.,	Date 2  14/2006  N & NEWNA CHESTER,	STEVEN M FUNE MD 216	SVILL RAL HO	E, MD	9 <b>0</b> n
il necolus, r.O. box 60	w requires that the death certifibeen signed by the attending should be detached for use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant condition  Closh Alim	1⊡Live bir 4⊡Pregna 9⊡ Unknov	nt at time of death 5			1 Te	acco use conto	tribute to the	ny Day Ye e cause of dea abiy 4 [Uni ssy findings av	ath? known
DIVISION OF VICE	fe fe	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 10 Natural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no determin	28a. Date of (Month)	patient 2 ER/Outpate Injury 28b. Time Injury 4thome, farm, so	of 28c. Injur Wor M 1 🗆	er: 4 \( \text{Nursing H}\)	ath Check only one tome 5 Resider 28d. Describe ho  28f. Location (Str. City or Town,	nce 6 Oth	er (Specify,	)	ЭГ,
-	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Co	one)	Physicien: To the baseminer: On the basemanner	pest of my knowledge, desists of examination and/or er stated.	investigation, in my o	pinion, death occu	rred at the time, da	te and place,	and due to	the cause(s)	
	To wit Cor	4	29b. Signature and title of certifier  30. Name and address of person with the control of the certifier and title of certifier and certif	no completed course	of death (Item 22a) /T		6 number 5 7635	29	d. Date signer	d (Month, D	2006	
- 4	Sta		31. Date filed (Month, Day, Year) SEP 1 2 2	2001	of death (Item 23a) (Type Medical) gistrar's Signature	PANCU	ung a	nnepelis	mo	214	(0)	
	Registr	ar	SEL TA 5	UUD CO	W D. GO	are I						

Amended Item 28f per M.E. 09/12/2006 Carroll County, Please Type or Print in Black Indelible Ink 06-06786 State of Maryland / Department of Health and Mental Hygiene Corey Redding 2006 30381 1- For State Certificate of Death Rea No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 0011 hrs Medical Examiner September 9, 2006 Corey Patrick Redding 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death University of Maryland Hosptial **Baltimore** If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7 Age (In yrs last birthday) **Funeral** Foreign Country) MD Months Davs Hours Min Director 01/04/1990 218-27-4168 16 1 M 2 Usual Residence of Decedent 10d Inside City Limits 10a State 10c City Town or Location Carroll 1 Yes 2 # No or items 23a or 28a-f show must be notified at once, MD Reisterstown ours after death with the Maryland 10e: Street and Number 10f. Zip Code 10g, Citizen of What Country 3510 Dumphries Dr. 21136 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian, Black. Armed Forces White, etc. 1 # Never Married 2 Married 2 # No Yes f Yes. Give Year Yes 2∰ No specify White Widowed Divorced Specify: "natural" ş 16a Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", MD 21215-0036 10 Student Education 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked ( Kimberly M. Kief James Truit Redding Be event, 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is James Truit Redding Father 3510 Dumphries Dr. Reisterstown MD 21136 Pages 1 and 2 s nent of Health a 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 # Burial 2 Cremation 3 Removal from State ment c Lake View Memorial 09/12/06 Sykesville, MD Donation 5 Other Specify Or. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licenses M00723 934 South Main Street Hampstead MD 21074 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure List only one cause on each line Retween Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy phy the 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Completed 24a Was an autopsy performed? death? Yes 2 V No Yes 2 26.Place of Death (Check only one) 25 Was case referred to medical Be

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: after death Director:

Yes 2 ✓ No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of No examiner? Hospital: Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Sep 8, 2006 27. Manner of Death 28b. Time of Injury 8c Injury at Work? 28d Describe how injury occurred Driver of auto involved in collsion 1454 hrs Natural 1 Yes 2 ✔ No 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number City or Town, State) **Hampstead, Maryland** Brodbeck Road North of Schaffer Drive, <del>Hapstea</del> Could not be Suicide determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License numbe

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 9, 2006

WIL 3

thin .

this

After

Certification:

cal

State Registra

O.C.M.E. person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner Jack Titus MD. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Registrar's Signature

and manner stated

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 30382 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SEPTEMBER 6, 2006 ROSE ANNE ROWAN 9:00 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 401 RUSSELL AVENUE, # 713 GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ F 89 Director 022-10-3221 Dec. 16, 1916 MASSACHUSETTS Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehov dical Examiner must be notified a 1∏Yes 2∏No Directo MARYLAND MONTGOMERY GAITHERSBURG the 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ō Iteme 23a 401 RUSSELL AVENUE, # 713 20877 U. S. A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 234 eny injury or other traumatic event, It is Medical Extrained in ust once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 K Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS EXECUTIVE SECRETARY U. S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN KRULFELD ANNA SLYPACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL D. ROWAN - DAUGHTER 12668 GRANITE RIDGE DRIVE, N. POTOMAC, MD. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State KING DAVID MEM. GDNS 9-8-2006 4 ☐ Donation 5 ☐ Other (Specify) FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service License DANZANSKY-GOLDBERG MEMORIAL CHAPELS Donald ( 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE AORTIC STENOSIS Physician /Medical Due to (or as a consequence of) Examiner HYPERLIPDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death. burial-transit ANEMIA and Due to (or as a consequence of) Box 68760, ettending physician by Physician/Medical ete hes been signed by the ettending phys page 2 should be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 1 Yes 2 X No 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home S Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 💢 No 3□ DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital c within 24 hours af To the Funeral D completely filled i Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of config 29c. License number 29d. Date signed (Month, Day, Year) D36797 SEPTEMBER 7, 2006 0 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN R. SHEFF, M. D. 10215 FERNWOOD ROAD, BETHESDA, MARYLAND 20817 31. Date filed (Month, Day, Year) SEP 11 32 Registrar's Signature 2006 Registrar

#### 06-06684

Gilberto Castro Rojas

#### Please Type or Print in Black Indelible Ink

	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			••
State of Maryla	and / Depa	rtment of Hea	alth and Menta	I Hygiene

2	0	n	5	3	n	3	8	
	U	U	0	ು	U	J	0	

	1- For St Registra					Ce	rtificate c	f Dea	th			Re	g. No.	201	U b	30	138
Physician	1. Deced	lent's Name	(First, Midd	le,Last)								ate of Death	h Day	Year	4	ime of Death	h
Medical Examine			erto		Cas		Ro	ojas			_ Se	eptembe	r 6, 200	06		0700 hrs	
		-	not institution		reet and numb	er)		4b, City, Whe		ocation of E	Death			ounty of Dea			
		Security N		6. Sex	17	Ago (In wee	last birthday)		der 1 Year	If Under 2	24⊔re Iα	Date of Rid		D/YYYY) 9. E		oca (State as	
Funeral Director	nor	ne			2F	33	Yr	Mont		Hours		ov.1		72 Fore	ountry	exico	<b>)</b>
ě.	10a. Sta	esidence of te	Ob. County			10c. City	, Town or Loca	ition							100	d. Inside City	Limits
Varyland 28a-f show any d at once.	IM E		Monto	gome	ry	R	Town or Loca OCKVi									Yes 2	No
tified the l	907	eet and Nun 7 Fir	st St	ree	t			10f. Zij	2085	0		10	-	n of What Co	untry?		
eath with items 2 items 2 ust be n	75 I	al Status ever Marrie	d 2 1 M	1 arried	<ol><li>Was Deced Armed Forc</li></ol>					anic Origin' Mexican, P		Yes or No- n, etc.)	14	Race - Ame White, etc.	erican	Indian, Black	ς,
after dea	3 V	Vidowed	L	orced If	Yes, Give Year Dates:	2 X No		Yes 2		specify: M			S		hi	te	
nours.	15. Dec			cify only	nighest grade		16a. Decede			on (Give kin DO NOT us		done	16b. Kin	d of Busines:	s/Indus	stry	
036 ithin 72 h ithe 72 h ithe 72 h ither "i	Eleme	entary/Seco 8	ndary (0-12)		College (1-4	or 5+)	1			alle:			Ca	rpet	Co	•	
21215-0036  uld be filed within 7  Mental Hygiene.  marked other than c event, the Medica	Jes	er's Name ( Sus C	First, Middle Castro	Last) Ma	rtine	z			1	8.Mother's I Flor	Name (Firs ida	t, Middle, M Rojas	Maiden Su S Ta	urname) acias	_		
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	9a. Info	rmant's Na Ciam	ne/Relations Selva	hip (Type AS G	alind	o/Nie	19b. Mailir CE 9	ng Addres 07 F	s (Street irst	and Numbe Str	er or Rural eet	Route Num Rock	ber, City Vill	or Town, Sta	te, Zip ryl	code) and2(	0850
Baltimore, Jernit. Pages I and Department of Heal Important: If iten injury or other tra	1 <b>X</b> B	thod of Disp urial 2		1 3 <u> </u>	Removal from		Place of Dispo crematory or c Eter				Dat 9 / 2 0		I	cation - City on ala, I			
Baltimol ermir. Pages Department of Important: I	21. Sign	of Fur	neral Service	rucensee	2'		13°1 9°1	111L1 241	podes. Colu	RIWA mbia	LDI Blv	FUNE d.Si	RAL lver	SERV:	ICE ing	,P.A.	910
Physician			e disease, or			sed the death	n. Do not enter								A	pproximate In	nterval
/Medical Examiner	Immedia		inal disease	a Mu	ultiple Injuri e to (oras a co		of):								-	Death	erund
	Sequent	tially list core	mediate		e to (or as a co	nsequence o	of):										
. ii	E (Distas	Enter Unde s or injury the esulting in a		C.	e to (or as a co	nsequence o	of):								+		-
				d											+		
ial jial		NPENDED			MENDED												
68760, certificate buding physic se as the buding			oregnant in t		23c. If yes, out 1 Live birth		2 F	etal death		Ectopic pr	regnancy			Date of delive onth	ery Day	Yea	ar
Box 6: death cert	past II. (	es 2 N	lo 9 🔲 Un	known	9 Unknow		eath 5 C	ther (Spe	ecify)				<b>1</b> 20				1
P.O. Box 687 s that the death certific gred by the attending p e detached for use as the		Other signif	icant condi	tions co	entributing to d	eath but not	resulting in the	underlyin	g cause gi	ven in Part I	l.			e contribute t			
w requires the second s									-		- 1	24a. Was a				y findings av	
COrc	Completed by										_	autops perfor	sy m <u>ed</u> ?	prior to death?	comp	letion of cau	se of
tal Rec		case refer	ed to medica	al I					26 Place	of Death (CI	beck only (	1 Yes 2	2 No	1 🗸	Yes	2	No
rital sician sician is cert	exan	niner?	process		pital: 1 Inc	atient 2	ER/Outpatier	nt 3		)thos:	Nursing Ho		Residenc	e 6 🗸 Oth	er Sce	ene	
Division of Vital Records, and or Attending Physician: The law requires after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should the street of the funeral director.	27 Man	Yes : ner of Deatl Natural			28a. Date of (Month, D	Injury	28b. Time of		28c. Injury	at Work?	28d.	Describe h	now injury				
Sion Attend death. rector:		Accident		ding stigation	Sep 6, 200	06	0655 hrs			es 2 V N	0						11.5
Division of Vital Rec pital or Attending Physician: The I ours after death. eral Director: After this certificate I filled in by the funeral director, page		Suicide Homicide		ld not be rmined		of Injury - At h Local Stre	nome, farm, str e <b>et</b>	eet, factor	y, office bu	ilding, etc.		or Town, St	tate)	Number or F rcola Dr.,			
S 4 E 2	29a. Cel (Check of one) 29b. Sig	n/v		miner: 0		examination	dge, death occ and/or investig									use(s)	
F 3 F 3	29b. Sig	nature and	title of certifi		1/ .	- d.		29	c. License	number			29d. Da	ite signed (N	fonth, i	Day, Year)	
	30 Nam	Ment address	hul oss of paren	who cor	npleted cause		n 23a)		O.C.N	1.E.			Septe	ember 7, 2	2006		
			. King, Jr		Assistan	Medical	Examiner			eet, Baltii	more, M	ID 21201					
Sta Registra	te <sup>31. Date</sup>	filed (Mont	SEP Year	117	32. Red	trar's Signat	ture &	bore	9								

4b. City, Town, or Location of Death

Reg. No 2 0 0 6

4c. County of Death

4:20 a M

Month Day Year September 9, 2006

2. Date of Death

26. Place of Death (Check only one)

Prince Frederick MD 20678

Mursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9/11/06

29d. Date signed (Month, Dey, Year)

Other:

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00060120

1 ☐ Yes 2 ☐ No

Certificate of Death

Scarpone

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Jessie

St. Mary's Charlotte Hall Veterans Home Charlotte Hall 8. Date of Birth (Month, Day, Year) Feb. 13, I If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🝊 F New York Yrs. 1928 78 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ANo St. Mary's Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? 20622 USA 29449 Charlotte Hall Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blair Nellie MacCrone Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9300 Bremerton Way, Montgomery Village, MD 20886 Francesca J. Watkins/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 9/12/2006 Charlotte Hall, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensus Brinsfield-Echols Funeral Home, P.A. 20622. Approximate Interval Between Onset and Death 23a. Phil Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heart Congestive
Due to (or as a consequence of): eumatoid Imonosus Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnatin the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 1 No 1 ☐ Yes 2 🗆 No

l or Attending Physician: The law requires that the death certificate be executed ed by the a cate has been sly, page 2 should b After this the Director: within 24 hours after To the Funeral Dire To the Hospital

State

Be

2

Certification:

Medical

25. Was case referred to

1 ☐ Yes 2 No

27. Manner of Death 1 (Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

5 Pending

AMMOW HOL

investigation

6 Could not be determined



MD

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State of Maryland / Department of Health and Mental Hygiene 0 6 30385 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OG. **Physician** DANIE SAYRES 0175 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/07/1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Months Days **Funeral** Months 1 M 2 F Yrs. RHODE ISLAND Director 83 039-01-5605 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "naturel", or iteme 23a or 28a-f show the Medical Example for motified at 1 ☐ Yes 2X No Funeral Director MD ANNE ARUNDEL ARNOLD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 633 DUNBERRY DRIVE TISA or Iteme 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 1 Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify. 3 Widowed 4 Divorced WW II WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ith and Mental Hygiene.
27 is marked other than "nr traumatic event, ILE MED Elementary/Secondary (0-12) College (1-4or 5+) AIR SAFETY INVESTIGATOR U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit timent of Health and Mental Hittent: If item 27 is marked oth jury or other traumatic even Be ဂ DANIEL A. SAYRES ELSIE CASSELBERRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH SAYRES / SPOUSE 633 DUNBERRY DRIVE, ARNOLD, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State SEPTEMBER 8. 1 ☐ Buriaf 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or otice. 2006 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Annroximate fnterval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ogas consequence of): Examiner physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as attending p IF FEMALE 23c, if ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 XNO 2 No 1 Yes 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Alter 1 Naturaf 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Medical 29a. Certifier 1 🕏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09.07.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPOLIS MOZIYU 74 M M A

State Registrar 31. Date filed (Month, Day, Year) SEP 1 2 2006

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 30386 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 10 2006 **Physician** 0100 M Doris Elaine Stonebraker /Medical Ctr 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village Health Care Carroll Westminster If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Apr 15 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ X Months 90 NJ Director 114-10-6661 Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Itema 23a or 28a-f show traumatic event, the Modical Exemble Figure 1. 1 XYes 2 No Director Westminster Carroll 10e. Street and Number 10g. Citizen of What Country? 201 St. Mark Way 21158 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify 3 □ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Its Ma Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marjorie Rapp Francis B. Smedes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2107 Bennett Point Rd Queenstown, MD 21658 William P. Stonebraker III/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Carroll Cremation, Inc. 19/11/2006 1 Burial 2 Cremation 3 Removal from State Hampstead, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for sels consequence offi-Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) the detached þ s been signed b should be deta Part II. Other significant conditions contributing to death but not result in a fit the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month, Day, Year) UKLE DO, H20558 MJ person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2006

		4	For State	State of Ma	aryland	/ Depa	artment of I	Health Death	and Me		iene eg. No.	200	5 3	038
	-		Registrar     Decedent's Name (First, Middle	, Last)			imodio oi	Doun		. Date of Deat	th		3. Time	of Death
	Physicia /Medic		GEORGE E	DWARD STI	LL,	SR			2	SEPT.	2, Day	2006	12:	05 ₺
	Examin		4a. Facility Name (If not institution				4b. City, Town, o					County of Deat		
			Washington 5. Social Security Number		Hosp		Tak		Park or 24 Hrs.   8	Date of Birth		MONTG(		te or Foreign
	Funeral Director		215-18-0454	1 <b>2</b> F	85	Yrs.	Months Days		Min.	Date of Birth (Month, Day, June 2	$3^{\text{Year}}$	921 co	New	Jerse
			Usual Residence of Decedent			Town or Lo								City Limits
	faryla et e	ŏ	10a. State 10b. County MD Mon	tgomery	Toc. City,		lver Sp	rina	r					es 2 🗆 No
	h the Maryland r 28a-f ehow	Director	10e. Street and Number	egomer y			10f. Zip Code		,	1	0g. Citiz	zen of What Co	untry?	
	th with	ai Di	2527 Ross R	Road , #201			2	0910	)			U.S.	Α.	
	n 72 hours after death with the Maryland "natural", or Items 23s or 28s-1 ehow adical Examiner must be nutilised at	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		13.	Was Decedent of I	Hispanic O an, Mexica	rigin? (Speci an, Puerto Ri	ty Yes or No- can, etc.)	1	14. Race - Ame Black, White		
30	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 √ Yes 2 □ N If Yes, Give Year or Dates:	¹o 44−	46	1☐ Yes 2☐ No	Specify	y:			Specify: B	lack	
315-003b	2 hou	ted	15. Decedent	's Education		16a. Dece	dent's Usual Occu	pation				nd of Business/	Industry	
212	within 72 ene. than "na he Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of work done DO NOT use retire	d)				outhea		_
7	led willygien her th		12th 17. Father's Name (First, Middle, I	( act)		T	ruck Dr	,		First, Middle, I		cycli	ng CC	)
and	d be findal h	) Be	John Still	LdS()				To. NOU		tta Da				
>	should nd Me mark	J.	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Stree	t and Numt	ber or Rural	Route Number	, City or	r Town, State, 2	Zip Code)	
Mai	and 2 alth a 27 to er tree		Wanda Still	(Daughter)		2527	Ross F	Road ,	Sil	ver Sp	rir	ng, MD	2091	.0
ore	of He		20a. Method of Disposition 1 □ gurial 2 □ Cremation	3 □Removal from State	cen	netery, crei	sition (Name of matory or other pla		Da Co			cation - City or		
altimore,	tan the Pa		4 □Donation 5 □ Other (S)	pecify)	Ash	Mem	orial C	cem	9/8/0	DEN F		ndy Sp		
g	permit. Pages 1 and 2 should Department of Health and Me Important: If Item 27 ie mark eny injury or other traumatione.		21. Signature of Funeral Service I	Licensee	udr	2	46 N. V	lashi	ingto	St.,	RC	ckvil	le. A	D-0
			23a. Fart1. Enter the dise st., or shock, or heart failure. List	complications that caused	the death.	D not en	er the mode of dy	ing, such a	s cardiac or	respiratory arr	est,		Approxir Interval	nate
	Physician	1 24	Immediate Cause (Final disease or condition				iomyopa.						Onset a	ars
,	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):								
	Lxammer	70	Sequentially list conditions,	b. Old I			l Infar	ctic	on	<u> </u>			10 y€	ears
	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<i>P</i>			ic Dise	ease					20 ye	ears
o,	en an		resulting in death) Last	Due to (or as										
09/8	cate be executed physiclen and the burial-transit	dicai		d Hyper	rtens	ion								
×	eath certifii attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	у						23d. Date of del	iverv	
. Box	death certifi e attending I ed for use as	Physician/Me	in the past 12 months?	1□Live birth 4□Pregnant at			]Ectopic pregnand ] Other <i>(specify)</i> _	у				Month	Day	Year
л Э	res that the de signed by the a be detached f	Phys	9 🗆 Unknown	9□ Unknown						T				
	The law requires that the ste has been signed by th bage 2 should be detache	by	Part II. Dther significant condition	Renal Fai		ing in the u	nderlyi <b>n</b> g cause gi	ven in Part	t I.			se contribute to ⊠No 3⊟Pr		
Vital Hecords,	w require been sig should t	letec	CHIONIC	Kenai rai.	<u>rure</u>					24a. Was a		24b. Were au		
ě	The lav	Completed								autops	med?	prior to death?	2 No	of cause of
Ita		BeC	25. Was case referred to medical examiner?					26. Plac	ce of Death (	1 □ Yes Check only on	2 M No	1 1 103	2 140	
	Physician: r this certifica ral director, p	၉	1 ☐ Yes 2 ☐ No	Hospital:		R/Outpatie	IL 3LI DOA					6 □Other (Spe	cify)	
50	ding F. After funera	tion:	27. Manner of Death 1 Natural 5 □ Pendin 2 Accident investig		Year) 2	8b. Time o Injury	Wo	ıryat ork? ]Yes 2.[		ld. Describe h	ow injur	y occurred		
Division of	Atten r deat ector: by the	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of Inj		ne, farm, st	reet, factory, office			If. Location (Si City or Town	treet and	d Number or Ri	ural Route N	lumber,
ā	ital or Ati	Cert	4   Aomicide	building, et	с. (Зреспу)					City of Yow	ri, Siale,	, 		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner sta	examination	ledge, deat on and/or in	h occurred at the t vestigation, in my	ime, date a opinion, de	and place, ar eath occurred	id due to the c d at the time, d	ause(s) late and	and manner as place, and due	stated. to the caus	e(s)
	within To the compl	Me	29b. Signature and title of certifier	1 Cto	1 11	22	29c. Licen	se number	r	2	9d. Dat	e signed (Mont	h, Day, Yea	r)
	2		) Jun			M	/ D:	2819	5		9.	-2-06		
			30. Name and address of person David A. G		eath (Item 2	23a) (Type,	Print) Georgia	Ave	. NW.	Wash:	ing	ton, D	C 20	011
3.	Sta	ite	31. Date filed (Month, Day, Year)											
**	Registr	ar	SEP 11	2006 Registr	, 15.	F. Da	NES!							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 09:10 AM SEPTEMBER 04, 2006 HILDA MAE STERLING /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** PRINCE GEORGE'S SHANTI GROUP HOME LAUREL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 Ø F Yrs MARYLAND SEPTEMBER 1, 1924 Director 220-18-2333 82 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "neturel", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No LAUREL MARYLAND PRINCE GEORGE'S Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6410 OLD SANDY SPRING ROAD 20707 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ĭ No Specify: Specify: δ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed v
Deperment of Health and Mental Hygie.
Important: If Item 27 is marked other 11
any injury or other traumatic event, this once. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN FLOOD 2 ERNEST CLEM 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16211 JERALD ROAD, LAUREL, MARYLAND 20707 YVONNE HOFFMAN - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GEORGE WASHINGTON CEMETERY 9/9/2006 ADELPHI, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HINES-RINALDI FUNERAL HOME, INC Melin 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CORONARY ARTERY DISEASE MANY YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed inding physiclen end use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No 9 Unknown 9 Unknown ş signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALZHEIMERS DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPOTHYROIDISM hes autopsy performed? certificete 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🔯 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this neral Director: After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJKUMAR BHOJRAJ, M.D., 5632 ANNAPOLIS ROAD, #10, BLADENSBURG, MARYLAND 20710 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 11 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 30389 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Pм ROBERT R. TUEL SEPTEMBER 8 2006 4:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GUEENSTOWN
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth (Month, Day, Year) QUEEN ANNE'S 7000 MAIN STREET Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 1**X**M 2□ F 04/25/1944 W۷ Director 214-42-9251 62 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28a-f ehow 1 ☐ Yes 2 ☑ No Director QUEEN ANNE'S QUEENSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7000 MAIN STREET 21658 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 **X**Yes 2 □ No If Yes, Give Year or Dates: **1961—1964** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: δ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 -0-MAINTENANCE BOATYARD MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY HESTER SIMMONS LEWIS ERVIN TUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 la 4016 BRADLEY CIRCLE, HURLOCK, MD 21643 MELISSA JUMP \_/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Department Important: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 09/13/2006 HURLOCK, MD HURLOCK, MD VETERANS 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Aur on each line. Approximate Interval Between Onset, and Death Small Cell CA at lun Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate authority. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à sign be 3 ☐ Probably 4 ☐ Unknown 19 Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 1 ☐ Yes 2 🖳 Be 25. Was case referred to medical examiner? tuneral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) ٩ 1 Yes 2 No this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: To the Hospitel or Attending 1 Aatural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar

State

29b. Signature and title of certifi

ely

31. Date filed (Month, Day,

30. Name and address of person who d

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

2118

2006

pleted cause of death (Item 23a), (Type, Print)

			For State Registrar		State of	Maryla	and / Depa <i>Ce</i>	artment of <i>rtificate o</i>	f He of D	alth and M <i>eath</i>	Mental H	ygiene Reg. No	2008	30390
			1. Decedent's Name (First,	Middle, Last)							2. Date of D	eath Da	y Year	3. Time of Death
	Physici /Medio		RICHARD S	SEHNG HS	IUNG TUNG	3			_				, 2006	9:25 P M
1	Examin		4a. Facility Name (If not ins	titution, give	street and num	ber)		4b. City, Town	n, or Lo	ocation of Death		4c.	County of Deat	th
			HOLY CROSS			A== //= -	un fant hinthulaus	SILV If Under 1 Ye		SPRING If Under 24 Hrs.	0 Date -4 D		MONTGOMER	
	Funeral Director		5. Social Security Number 231-96-8920		M 2□F	. Age (iii )	vrs. last birthday) Yrs.	Months Day		Hours Min.	8. Date of B (Month, D MARCH	ay, Year)		thplace (State or Foreign buntry) TATWAN
	and		Usual Residence of Deceder 10a. State 10b. C			10c.	City, Town or Lo	cation						10d. Inside City Limits
	Mary -f eho	ğ	MARYLAND	MONTGOM	ERY			ROCKVILLE	₹.					1 ☐ Yes 2 🎇 No
	r 28a	Director	10e. Street and Number					10f. Zip Code				10g. Cit	izen of What Co	ountry?
	th with		4602 AS	PEN HIL	L ROAD				208	53			U.S.A	١.
	dea	Funeral	11. Marital Status		12. Was Deced	ent Ever in	n U.S. 13.	Was Decedent of	of Hisp	anic Origin? (Sp Mexican, Puerto	ecify Yes or N	10-	14. Race - Ame Black, Whit	
21215-0036	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Health and Mental Hygiene. If Hem 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Macheal Exacultant court by mutiliad at	Ď	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 ☐ Yes 2 If Yes, Give Year or Dat	. No	1	1□Yes 2⊠N		Specify:	,		Specify:	SIAN
<u>ب</u>	72 ho	ted	15. De (Specify only	cedent's Edu	cation		16a. Dece	dent's Usual Occ	cupatio	on ina most of work	ina	16b. K	ind of Business/	Industry
2	ithin and a second	Completed	Elementary/Secondary (0		Cottege (1-	4or 5+)	life.		tired)	ing most of work	y			
2	ted w lygier her th	ဝိ	12	i ( (   1 1 )				COOK	44	0. Markada Na	- 15: 11:	- 44-14 -	PRIVATE	
Maryland	be fi	Be	17. Father's Name (First, M	,					18	B. Mother's Nam			Sumame)	
ž	d Mer nark	ဥ	YU T		no Drintl		106 Mail	a - Address /Ctra		AH d Number or Run	MEI CHE		Town State	Tin Contain
Na	d 2 st th and 7 is r traur				, , ,									zip Code)
	1 an Heal tem 2		JULIE L. TUNG 20a. Method of Disposition	- WIFE		20	b. Place of Dispo cemetery, crea			ROAD, ROCI	Date	-	ocation - City or	Town, State
more,	Pages nent of I int: If Its iry or o		1 ☐ Burial 2 ☑ Crem. 4 ☐ Donation 5 ☐ Ot		emoval from S	iaio				0/10	/2006	DDEN	TTLICOD MA	DVI AND
副	그 문문을		21. Signature of Funeral Se		90	1	FORT LINCO			of Facility HII		_	TWOOD, MA	
ď	Depa Impo Impo Pany ii	6	Much	NTI	Golei	1								ARYLAND 20904
			23a. Part1. Enter the disea shock, or heart failure	se, or compl	cations that ca	used the d	leath. Do not en	er the mode of o	dying,	such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	,			SIS MENING	ITIS					19	Onset and Death
	/Medical		resulting in death)				sequence of):							
	Examiner		Sequentially list conditions			and the same of	LUNG CANCE	:R						
	sit ad	iner	Soutor tally list our dillions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, <b>1</b>	Due to (o	ras a con	sequence of):							
	and I-tran	Examiner	that initiated events resulting in death) Last	•	Due to (o	ras a con	sequence of):				-			
68760,	icate be executed physicien and s the burial-transit	aiE		- t		. 45 4 55	304431133 377.							
687		edicai			1									
P.O. Box	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	111	3c. If yes, outco 1 □ Live bir 4 □ Pregna 9 □ Unknov	th 2 ☐ F nt at time (	etel death 3	Ectopic pregnal Other (specify)					23d. Date of del Month	ivery Day Year
	that	by Pt	Part II. Other significant co	nditions cor	ntributing to dea	ith but not	resulting in the u	nderlying cause	given	in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
rds	quire on sig uld bi										1	Yes 2	□No 3□Pr	obably 4 \( Unknown
Division of Vital Records,	ne law requir has been si ge 2 should l	Completed									24a. Wa auto	s an opsy formed?	24b. Were au prior to death?	itopsy findings available completion of cause of
ā		e Co	25. Was case referred to m	edical						C. Place of Post		2K) No	1 🗆 Yes	2 No
5	/sicia s cert direct	To B	examiner?	-	lospitat:	patient 2	2 ER/Outpatier	nt 3 DOA	Other:	<ol> <li>6. Place of Deat</li> <li>4 ☐ Nursing Ho</li> </ol>			6 🖾 Other (Sne	cify) HOSPICE
ō	Attending Physician: The Ir death. c death. ector: After this certificete ha		27. Manner of Death		28a. Date of		28b. Time o		njury at		28d. Describe			HOSPICE
<u>ö</u>	ath. pr: Aft	atlo	2 Accident	Pending nvestigation	(Worter	, Day 10a	Hijary			s 2□No				
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ertification:	3 Suicide 6 0 4 Homicide	Could not be determined	28e. Place of building	of Injury - A g, etc. <i>(Sp</i>	t home, farm, st ecify)	eet, factory, office	Ce			(Street and		ural Route Number,
	ospite hours unerel ly filler	calC	29a. Certifier 1 🗓 Ce	rtifying Phys	sician: To the b	est of my	knowledge, deat nnation and/or in	h occurred at the	e time,	date and place,	and due to the	e cause(s)	and manner as	stated.
	the H nin 24 the F nplete	Medical	one)		and manne	er stated.					ou at the fille			
	Twith Court	~	29b. Signature and title of o	entitier (	)	1		29c. Lice				29d, Da	le signed (Monti	n. Day, Year)
1	V			~ 4		X			0625	71		SE	PTEMBER 6	, 2006
		10	30. Name and address of p SARAH BROMELA						SDR	TNG. MARVI	AND 200	10		
	Sta	te	31. Date filed (Month, Day,		20 B-	aintenda Ci			DI IV.	IMMII emi	ANID 207.			
	Registr		SEP		106	CHA.	J. Ap	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene? [] [] [6] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Jean Blake Thompson her 15,200 sept en /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100 Walnut Lane Ceci1 E1kton Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖫 F Months Director Maryland 222-05-8434 July 27, 1919 Usual Residence of Decedent the Maryland ehow. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f sho other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Department of Health and Mental Hygiene.
Important: If item 27 ie marked other then "n-the marked other the marked other then "n-the marked other the marked other then "n-the marked other the marked 100 Walnut Lane 21921 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. ☐Yes 2 🕅 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2) No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Vice President/Corporate Secretary Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stewart C. Strickland Ethel George ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert S. Blake/Son 238 Black Snake Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, 20a. Method of Disposition September 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. Inc. 16, 2006 Pennsylvania 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hear **Physician** Con restiv disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy be detached for Year Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 🗆 No 1 ☐ Yes efter death.

Director: After this certification by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeref L Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stasons 45 ar

State Registrar 31. Date filed (Month, Day, Year)

32. Registra 's Signature

2 5 2006

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 1 2006

32. gistrar's Signature

			1 - For State Registrar	State of Marylar		artment of rtificate of			giene 2006	30393
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	ngardj				2. Date of Dea Month	Day Year 8 200 (	3. Time of Death  1.08AM
	Examin Funeral		4a. Facility Name (If not institution, give s  MINT-GOMERY CENE  5. Social Security Number  6. Sey	rAl Hospita	last birthday Yrs.	Olne		rs. 8. Date of Birth	r, Year) Coi	DENY holace (State or Foreign untry)
	Director		Usual Residence of Decedent		ty, Town or L	ocation		Jan. 18	, 1918 Penr	10d. Inside City Limits
	or 28a-f	Director	Maryland Montgome  10e. Street and Number	ery	Roc	kville 10f. Zip Code			10g. Citizen of What Co	1 Yes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportant: If Items 21 a marked other then "natural", or Items 23a or 28s-f show important: If them 27 is marked other then "natural", or Items 23a or 28s-f show eny Injury or other traumatic event, Ite Medical Examination must be notified at ance.	Completed by Funeral Director		AVenue 12. Was Decedent Ever in U Armed Forces? 1 ™ Yes 2 □ No WW If Yes, Give Year or Dates: 194	II	20853 Was Decedent of If Yes, specify Cu	ban, Mexican, Pu	(Specify Yes or No- and Rican, etc.)	USA  14. Race - Amer Black, White  SpecifyWhit	e, etc.
21215-0036	d within 72 ho giene. er then "netu	ompletec	15. Decedent's Edu- (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	edent's Usual Occi e kind of work don DO NOT use retii	e during most of w	rorking	16b. Kind of Business/I	ndustry Inforcement
and	d be file ental Hy ced oth c event	To Be (	17. Father's Name (First, Middle, Last)  Anthony Zangardi					ame <i>(First, Middl</i> e, Ctoria Bu		
Maryland	2 should and Men is marks raumatic	F	19a. Informant's Name/Relationship (7y) Elizabeth A. Kitts	· ·	1	-	at and Number or	Rural Route Numbe	r, City or Town, State, Z	
Baltimore, I	Pages 1 and nent of Health int: If Itam 27 iry or other to		20a. Method of Disposition 1	emoval from State	Place of Disp cemetery, cre	osition (Name of ematory or other pi aven Cemet	ace)   Sep	ot. 11,	ney, MD 208	Fown, State
	Departme Departme Importan eny Injur		21. Signature of Funeral Service License		1 2	2. Name and Add	ress of Facility		Home Inc. lver Spring	, Maryland
8760,	Character be executed by National and Character street in the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	iter the mode of d	ring, such as cardi	ac or respiratory an	est,	Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certific sie has been signed by the atlending p page 2 should be detached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 0 9 □ Unknown	al death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of delin	very Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the	underlying cause g	iven in Part I.		bacco use contribute to es 2 □ No 3	the cause of death? Sably 4 □Unknown
Division of Vital Records,	: The law re cete has be page 2 sho	Completed	=======================================					24a. Was a autop perfor 1 Yes	sy prior to c	opsy findings available ompletion of cause of
<u> </u>	Physician: r this certifice ral director, p	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatie	int 3□ DOA C		eath (Check only or		2.5
ion of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: To	27. Manner of Death  atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inj	4 🗀 Nursing		ence 6 Other (Specow injury occurred	ity)
Divis	tal or Attars after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		treet, factory, office		28f. Location (S City or Tow	treet and Number or Rui n. State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier Check only one) Certifying Physical Check only 2 Medical Examination	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date and pla opinion, death oc	ce, and due to the c curred at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)
is	To the within 24 To the Complete	Me	29b. Signature and title of certifier	1 HD		29c. Lice	nse number 06319	6	9d. Date signed (Month	. Day, Year)
1	,		30. Name and des of person who co	mpleted cause of death (Itel	п 23a) (Туре Руми)	Print)	Drive	dinou	MD 20	832
S.	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 1 200	32 Registrar's Sign	ature	weeks.	1		•	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

				<b>ype or Print in Bla</b> State of Maryland /				
		•	1 - For State Registrar	otato of marytana /	Certificate of		Rag. No	D.
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	VERY			2. Date of Death Month Da	Year 3. Time of Death
Ĭ.	Examin		4a. Facility Name (If not institution, give s			or Location of Death	40	c. County of Death
Ŧ	Funeral Director		Northwest Hospi 5. Social Security Number 6. Sex 212.46.8159	+al 7. Age (In yrs. last)  M 2□ F  5  8	birthday) If Under 1 Year Months Days	andalista If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	Baltimore  9. Birthplace (State or Foreign Country)
þ			Usual Residence of Decedent  10a. State 10b. County		own or Location			10d. Inside City Limits
Maryla	o ho	ror	MD Baltim		Pikesville			1 ☐ Yes 2 Dolo
th the	or 28a	Olrec	10e. Street and Number	10	10f. Zip Code		10g. C	itizen of What Country?
death with the Maryland	18 23a Tust k	Funeral Directo	609 leafydale	2. Was Decedent Ever in U.S.		208 Hispanic Origin? (Spec	cify Yes or No-	14. Race - American Indian,
5-0036		by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of It Yes, specify Cub	an, Mexican, Puerto F Specify:	Rican, etc.)	Black, White, etc.  Specify: BKCL
לים ה	natur	eted	15. Decedent's Educ (Specify only highest grade	ation 16 completed)	Sa. Decedent's Usual Occup (Give kind of work done	during most of working	16b. i	Kind of Business/Industry
Z digital	then the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire		1+01	ese of Muth
and 2	al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	Hyears	trogram mo	18. Mother's Name	(First, Middle, Maide	
ylar Vigit	Department of Health and Mental Hygienes Important: If item 27 is marked other than any injury or other treumatic event, Ita Ma once.	70	Theodore Avery	1.00	05-14-15-14-14-1-17	Alvini	a Cash	or True Chate 71- Code)
Mai	Ith and 27 is n		19a. Informant's Name/Relationship (Tyr.) Gwendolyn D. Ave.	rul wife le	9b. Mailing Address (Street	F TETTACE	Dikentili	or 10wn, State, 21p Code)  MD 21208
ore,	of Head fitem r oths		20a. Method of Disposition  1 Surial 2 Cremation 3 Re	20b. Place	of Disposition (Name of otery, crematory or other pla	ce) D	,	ocation - City or Town, State
TIMOL	rtment rtant: i		4 Donation 5 Other (Specify)	Wo	odlaun	9120	100 WOO	eene funeral service
Balt	Depa impo any ir		21. Signature of Funeral Service License	reene	8709 lib	erty ka		mo 21133
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. D	o not enter the mode of dyi			Approximate Interval Between
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)		MHTIW AMO	ETASTASE	STOES	Onset and Death
	xaminer		W. I. DOVENNESS CONT.	Due to (or as a consequence	ce of):			
/ 5	2 <del>=</del>	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):			
δυ, λ δυστορία	sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):			
		ल	d					
X OX	attending physical for use as the [	/Med	IF FEMALE:	Sc. If yes, outcome of pregnancy			1	
ecords, P.O. Box 68/	the attenent	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		у		23d. Date of delivery Month Day Year
י, ק	been signed by the should be detached	by Ph	Part II. Other significant conditions con	ributing to death but not resulting	g in the underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to the cause of death?
ecords,	een sig	ted					1 ☐ Yes 2	Probably 4 Unknown
ř	ate ha	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  o 1 ☐ Yes 2 ☑ No
Vital	certificate ha	Be	25. Was case referred to medical examiner?	ospital:	C	26. Place of Death	***************************************	
O	r this o	5	1 ☐ Yes 2 No	1 Dainpatient 2 LEH/	b. Time of 28c. Inju	4   Nursing Hon	ne 5 Residence	
פוני	ath. or: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		rk? ]Yes 2 No		
DIVISION OF VITA	within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office	2	28f. Location (Street a City or Town, Sta	nd Number or Rural Route Number, te)
9	24 hour	Medical		ician: To the best of my knowled ler: On the basis of examination and manner stated.				s) and manner as stated. nd place, and due to the cause(s)
Ę	within To th	Me	29b. Signature and title of certifier	rella mo		se number		ate signed (Month, Day, Year)
	m					1410		lember 21, 2006.
			30. Name and address of person who co			HOER PT	*	33 ,
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Goarde	No.		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

				ype or Print in E State of Marylan					30395
			1 - State Registrar			te of Death	Reg		
	Physicia /Medic	_	1. Decedent's Name (First, Middle, Last)  Clara Este	lle Ande	nson		2. Date of Death Month	Day Year	
	Examin	- to	4a. Facility Name (If not institution, give st	reet and number)	0	, Jown, or Location of Death		4c. County of Deat	th A
	Funeral Director		5. Social Security Number 6. Sex 218-10-5782 1□	м 2 <b>Д</b> F		er 1 Year   If Under 24 Hrs.	8. Date of Birth Month, Day, Y	9. Bird 1,1917 M	thplace (State or Foreign buntry) ARYLAND
	72 hours after death with the Maryland Insturat', or tiems 23a or 28a-f show digst Examiner mant be notified at	tor	Usual Residence of Decedent  10a. State  10b. County  MARVIAND	10c. City	, Town or Location	LTIMORE	CITY		10d. Inside City Limits 12 Yes 2 □ No
	vus after death with the Marylan rat', or items 23a or 28a-f ahow Examitiet finest be notified at	I Directo	10e. Styleet and Number	BAITIMARE		ip Code		Citizen of What Co	ountry?
	r death	Funeral	11. Wantai Status	2. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No	S. 13. Was Dec	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puen	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
5-0036	ours afte	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Specify: B	LACK
_	c * @	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's Us (Give kind of w life. DO NOT	rork done during most of wor	rking 16	b. Kind of Business	/Industry
212	o filed within I Hygiene. other then "yent, in Mac	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	DOM		RKER I		PAMILIES
and	e d a	To Be	17. Father's Name (First, Middle, Last)	ANI	DERSON	ANN		BR	OWN
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Typ	Print)	19b. Mailing Addres	ss (Street and Number or Ru	ural Route Number, C	ity or Town, State, .	Zip Coda)
ore,	ges 1 and t of Health If item 27 or other to		20a. Method of Disposition  1 Burial 2 Cremation 3 Re		lace of Disposition (Nemetery, crematory or	ame of other place)	Dite 20	c. Location - City or	Town, State
altimore,	Pa men ury		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License	We	22. Name	EME, 09-	29-06 0	NOODLA	WW. MARYLAND
Ba	permit. Departr imports any infi		Wahreh	N. Willia	02/4	and Address of Facility SEPHH. A	ON MYEVE	BALTO. 1	4021217
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	Arrest		c or respiratory arres	•	Approximate Interval Between Onset and Death
ψn	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq		· · · · · · · · · · · · · · · · · · ·			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Extending to immediate	Due to (or as a conseq	Epilepi uence of):	1205			
Š	be executed sicien end burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
3760,	ate be e hysicien the burit	<u>e</u>	<b>U</b> <sub>d</sub>						
89 xo	death certificate attending physicate	n/Mec	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna				23d. Date of de	- /
P.O. Box	Attending Physician: The law requires that the death certificate or death.  ector: After this certificate has been signed by the attending physicate. After this certificate as bould be detached for use as the by the funeral director, page 2 should be detached for use as the	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 🕱 No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown				Month	Day Year
	res thet the de signed by the a be detached f	þ	Part II. Other significant conditions con-	tnbuting to death but not res	ulting in the underlying	cause given in Part I.	23e. Did toba	10	o the cause of death?
Records,	w requires been si	Completed					24a. Was an	24b. Were a	utopsy findings available
H Re	: The lav	Comp					autopsy performe 1 Yes 2	od? death? No 1 ☐ Yes	completion of cause of
<u> </u>	/sician s certif director	To Be	25. Was case referred to medical examiner?  1 Yes 2 Yo	ospital: 1 X Inpatient 2 🗆	ER/Outpatient 3□ t	Other	ath <i>(Check only one)</i> Home 5 ☐ Residen		ecify)
on of	ling Phy L. After thi unerat c		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 🕱 No	28d. Describe how		
Division of Vital	i or Atteno after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, facto		28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number.
u	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier	sician: To the best of my knoter: On the basis of examina and manner stated.	owledge, death occurre	ed at the time, date and place on, in my opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within ?	Mec	29b. Signature and file of contract	A c	2	9c. License number	290	d. Date signed (Mon	th, Day, Year)
}	3		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, Print)	P16660		1123/0	6
-	3		Holly Minson,	16 S. Eug 32. Registrar's Signa		BaHmore	MD	21201	
4	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 6 2006	32. Registrar's Signa	ature				

		1- For State Registrar	ate of Maryland	•	it of Health and e of Death	Mental Hy	/giene Reg	No 25	106 303
Physicia Iical Exami	an/	Decedent's Name (First, Middle John Robert Argument)					2 Date of Death Month D	ay Year	3. Time of Death 1737 hrs
iicai Exaiiii	Hei	4a. Facility Name (if not institution			4b City, Town, or Lo	ocation of Death	September 1	5, 2006 4c. County of Dea	
		1905 Lemmon Street			Baltimore			n/a	
Funeral Director		5. Social Security Number 215–66–3728	6. Sex 7. Agr	e (In yrs. last birthda	Yrs. If Under 1 Year  Months Days	If Under 24Hrs Hours Min	Sept. 7	1956 For	Birthplace (State or eign Country) Md.
any		Usual Residence of Decedent  10a State 10b. County		10c. City, Town or			····		10d Inside City Limits
rland -f show once.	tor	Md. n/a		Baltim					1 X Yes 2 No
e Mary or 28a-	Director	10e. Street and Number 4241 Pascal Av	ronijo		10f. Zip Code		10g.	Citizen of What Co	ountry?
with th		11. Marital Status	12. Was Decedent	Ever in U.S 1	21226 3 Was Decedent of Hispa			USA 14. Race - Am	erican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menland Hygiene Department of Treath and Menland Hygiene Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 Never Married 2 X Ma 3 Widowed 4 Dive	1 Yes 2	X No	If Yes, specify Cuban, No.		Rican, etc.)	White, etc.	nite
nours a natura xamir	ed by	15. Decedent's Education (Spec		dur	cedent's Usual Occupation			b. Kind of Busines	
36 bin 72 l than "-	Completed	Elementary/Secondary (0-12)	College (1-4 or 8	5+)	uto Painter		,	Repair	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Com	17. Father's Name (First, Middle,		l A		Mother's Name	(First, Middle, Maid		
121; d be fill lental F arked	Be	John Robert Ar				innie W			
MD 2 nd 2 shoul alth and M un 27 is un aumatic e	ပ	19a. Informant's Name/Relations Jeannie Phelps			Mailing Address (Street a				
e, N I and I Health item I		20a. Method of Disposition	•	20b. Place of D	isposition (Name of ceme or other place)			c. Location - City	
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr	$\bigcap$	Burial 2 X Cremation  Donation 5 Other St			v Crematory	9/2	1/2006   E	Baltimore	, Maryland
Salti ermit. epartm nporta njury o	1	1. Signature of Funeral Service			22. Name and Address of	Facility Hul	bbard Fur	eral Hom	e, Inc.
Physician	ii.ON	23a. Part I. Enter the disease, or	complications that caused		4107 Wilken	s Avenue	e, Baltın	ore, Mar	y Land 21229 Approximate Interval
/Medical	0. 1	failure. List only one cause Immediate Cause (Final disease	on each line.		and cocaine us		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Between Onset and Death
xaminer	Н	or condition resulting in death)	Due to (or as a conse						
art.	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):					-
	ᆵ								
	톭	cause Enter Underlying Cause (Disease or injury that initiated	C Due to (or as a conse	ad lence of):					4
outed nd ransit	l Examiner	cause Enter Underlying Cause	Due to (or as a conse	equence of):					
be executed ician and arial - transit	_	cause Enter Underlying Cause (Disease or injury that initiated	d		8a-f,perME,g859	9,9/27/06	TT		
3760, ficate be executed g physician and s the burial - transit	_	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the	d.  AMENDED ita  23c. If yes, outcome	em#23a,27,28	Ba-f, perME, g859			23d. Date of delive	
x 68760, th certificate be executed ttending physician and r use as the burial - transit	_	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  VINPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d.  AMENDED it.  23c. If yes, outcon 1 Live birth 4 Pregnant at	em#23a,27,28		9,9/27/06 Ectopic pregnar		23d. Date of delive Month	ery Day Year
. Box 68760, the death certificate be executed y the attending physician and the for use as the burial - transit	sician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unk	d.  AMENDED itc  23c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	em#23a,27,26 ne of pregnancy time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnar	ncy	Month	Day Year
P.O. Box 68760, so that the death certificate be executed gened by the attending physician and be detached for use as the burial - transit	by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  VINPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d.  AMENDED itc  23c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	em#23a,27,26 ne of pregnancy time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnar	23e. Did tobac	Month	
rds, P.O. Box 68760, requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burnal - transit	by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unk	d.  AMENDED itc  23c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	em#23a,27,26 ne of pregnancy time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnar	23e. Did tobad 1 Yes 2	Month  co use contribute to th	Day Year  o the cause of death?  obably 4 Unknown  autopsy findings available
ecords, P.O. Box 68760, he law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial - transit	by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unk	d.  AMENDED itc  23c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	em#23a,27,26 ne of pregnancy time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnar	23e. Did tobac 1 Yes 2 24a. Was an autopsy performe	Month  co use contribute l  No 3 Pr  24b. Were a prior to death?	Day Year  o the cause of death?  obably 4 Unknown  autopsy findings available o completion of cause of
al Records, P.O. Box 68760,  an: The law requires that the death certificate be executed ertificate has been signed by the attending physician and ctor, page 2 should be detached for use as the burial - transit	Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unk  Part II. Other significant conditions and the past 12 months?  25 Was case referred to medical	d.  AMENDED  itu  23c. If yes, outcon  1 Live birth  4 Pregnant at  9 Unknown  ons contributing to death	em#23a,27,26 ne of pregnancy time of death 5	Fetal death 3 Other (Specify) the underlying cause give	Ectopic pregnar	23e. Did tobac 1 Yes 2 24a. Was an autopsy performe 1 Yes 2	Month  co use contribute I	Day Year  o the cause of death?  obably 4 Unknown  autopsy findings available o completion of cause of
'Vital Records, P.O. Box 68760,  Physician: The law requires that the death certificate be executed  rthis certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial - transit	o Be Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d.  AMENDED ite 23c. If yes, outcon 1 Live birth 4 Pregnant at 9 Unknown Ons contributing to death	em#23a,27,26 ne of pregnancy time of death 5 n but not resulting in	Fetal death 3 Other (Specify) the underlying cause give	Ectopic pregnar en in Part I.  Death (Check o	23e. Did tobac 1 Yes 2 24a. Was an autopsy performe 1 Yes 2	Month  Co use contribute to the contribute of th	Day Year  o the cause of death?  obably 4 Unknown  autopsy findings available o completion of cause of  Yes 2 No
on of Vital Records, P.O. Box 68760,  dding Physician: The Jaw requires that the death certificate be executed the Arther this certificate has been signed by the attending physician and thoreal director, page 2 should be detached for use as the burral - transit	To Be Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unk  Part II. Other significant conditions are assuminer?  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	d.  AMENDED  itu  23c. If yes, outcon 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death  Hospital: 1 Inpatie  28a. Date of inju (Month, Day, Y	em#23a,27,28 ne of pregnancy  2 time of death 5 n but not resulting in  ant 2 ER/Outp.  12 ER/Outp.  13 ER/Outp.  14 ER/Outp.  15 ER/Outp.  16 ER/Outp.  17 ER/Outp.  18 ER/Outp.  18 ER/Outp.  18 ER/Outp.  18 ER/Outp.	Fetal death 3 Other (Specify)  the underlying cause give  26 Place of atient 3 DOA Other of Injury 28c. Injury 3	Ectopic pregnar en in Part I.  Death (Check o	23e. Did tobac 1 Yes 2 24a. Was an autopsy performe 1 Yes 2 inly one) 9 Home 5 Res 28d. Describe how	Month  Co use contribute to the contribute of th	Day Year  o the cause of death?  obably 4 Unknown  autopsy findings available o completion of cause of  Yes 2 No
ission of Vital Records, P.O. Box 68760,  Attending Physician: The law requires that the death certificate be executed each terror: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Very and the past 12 months?	d.  AMENDED ite  23c. If yes, outcom 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death  Hospital 1 Inpatie  28a. Date of Inju (Month, Day, Y  Fnd 9/15,	em#23a,27,28 ne of pregnancy time of death 5 n but not resulting in the second	Fetal death 3 Other (Specify)  the underlying cause give  26 Place of atient 3 DOA Other atient 3 DOA Other State of Injury 28c Injury 3	Ectopic pregnar en in Part I.  F Death (Check o	23e. Did tobac  1 Yes 2  24a. Was an autopsy performe 1 Yes 2  inly one) 9 Home 5 Res 28d. Describe how	Month  co use contribute to the contribute of th	o the cause of death? obably 4 Unknown autopsy findings available o completion of cause of Yes 2 No
Division of Vital Records, P.O. Box 68760, one Artending Physician: The law requires that the death certificate be executed nour after death errain Director. After this certificate has been signed by the attending physician and rilled in by the funeral director, page 2 should be detached for use as the burial - transit.	To Be Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    X UNPENDED	d.  AMENDED ite  23c. If yes, outcom 1 Live birth 4 Pregnant at 9 Unknown  Ons contributing to death  Hospital 1 Inpatie  28a. Date of Inju (Month, Day, Y Fnd 9/15, d not be	em#23a,27,28 ne of pregnancy time of death 5 n but not resulting in the second	Fetal death 3 Other (Specify)  the underlying cause give  26.Place of atient 3 DOA Other of Injury 28c. Injury 1  5:20 pm	Ectopic pregnar en in Part I.  Death (Check o	23e. Did tobact  1 Yes 2  24a. Was an autopsy performe  1 Yes 2  inly one)  2 Home 5 Res 228d. Describe how  unknown  28f. Location (Stre or Town, State	Month  co use contribute to the contribute of th	Day Year  o the cause of death? obably 4 Unknown autopsy findings available completion of cause of  Yes 2 No  er Scene
Division of Vital Records, P.O. Box 68760, the Hospita or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The this certificate has been signed by the attending physician and ribe Funeral Director. After this certificate has been signed by the attending physician and upletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    X UNPENDED	d.  AMENDED ite  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death  Hospital: 1 Inpatie  28a. Date of injute (Month, Day, Y  Fnd 9/15, 28e. Place of Indicated (Specify) He	em#23a, 27, 28 ne of pregnancy time of death 5 n but not resulting in the series of th	Fetal death 3 Other (Specify)  the underlying cause give 26 Place of attent 3 DOA Other of Injury 28c. Injury 3 treet, factory, office build occurred at the time, date	Ectopic pregnar en in Part I.  Death (Check o	23e. Did tobact  1 Yes 2  24a. Was an autopsy performe  1 Yes 2  inly one)  2 Home 5 Res 228d. Describe how unknown  28f. Location (Streor Town, State Baltimore, due to the cause(s)	Month  co use contribute to the prior to the death? Injury occurred  and number or Form 1905 Lemmy and manner as stored.	o the cause of death? obably 4 Unknown autopsy findings available o completion of cause of Yes 2 No er Scene  Rural Route Number, City on Street
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit	Certification: To Be Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unk  Part II. Other significant condition  25 Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pence 2 Accident 3 Suicide 6 X Couled the Couled	d.  AMENDED  itu  23c. If yes, outcom  1 Live birth  4 Pregnant at  9 Unknown  ons contributing to death  28a. Date of Inju  (Month, Day, Y  Fnd 9/15,  28e. Place of In  (Specify) Ho  ryssician: To the best of my  miner: On the basis of exar  and manner stated	em#23a, 27, 28 ne of pregnancy time of death 5 n but not resulting in the series of th	Fetal death 3 Other (Specify)  the underlying cause give 26 Place of attent 3 DOA Other of Injury 28c. Injury 3 treet, factory, office build occurred at the time, date	Ectopic pregnar en in Part I.  Death (Check o ther Wursing at Work? s 2 X No ding, etc  and place, and o eath occurred at	23e. Did tobac  1 Yes 2  24a. Was an autopsy performe 1 Yes 2  Inly one) 2 Home 5 Res 28d. Describe how  unknown 28f. Location (Stre or Town, State Baltimore, due to the cause(s) the time, date and	Month  co use contribute to the prior to the death? Injury occurred  and number or Form 1905 Lemmy and manner as stored.	o the cause of death? obably 4 Unknown autopsy findings available completion of cause of Yes 2 No er Scene  Rural Route Number, City ion Street arted.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    X UNPENDED	d.  AMENDED ite  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  ons contributing to death  Hospital: 1 Inpatie  28a. Date of injute (Month, Day, Y  Fnd 9/15, 28e. Place of Indicated (Specify) He	em#23a, 27, 28 ne of pregnancy time of death 5 n but not resulting in the series of th	Petal death 3 Other (Specify)  the underlying cause give the underlyin	Ectopic pregnar en in Part I.  Death (Check o ther Nursing at Work? s 2 X No ding, etc  and place, and o eath occurred at humber	23e. Did tobac  1 Yes 2  24a. Was an autopsy performe 1 Yes 2  inly one) 2 Home 5 Res 28d. Describe how  unknown  28f. Location (Streor Town, State  Baltimore, due to the cause(s) the time, date and	Month  co use contribute to the contribute of th	o the cause of death? obably 4 Unknown autopsy findings available ocompletion of cause of Yes 2 No er Scene  Rural Route Number, City ION Street arted. the cause(s)

		1 - For State Registrar	State of Maryland	/ Department of Health and I Certificate of Death	Mental Hygien Reg. N	ZUUb	30397
Physi	cian	1. Decedent's Name (First, Middle, La	BANTH	1	2. Date of Death	ay Year	3. Time of Death
/Med Exam	dical liner	4a. Facility Name (If not institution, gir		4b. City, Town, or Location of Death		c. County of Death	20
Lxan		JOHNS HOPHING BAY	VIBU MEDICAL CA	ENTE BALTIMORE	=		
Funera Directo		5. Social Security Number 6.  212 -26 -6693  Usual Residence of Decedent	Sex 1 ☐ M 200 F 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs.  Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthpl Count	ace (State or Foreign try) 24/4wD
ryland		10a. State 10b. County	10c. City,	Town or Location		10	Od. Inside City Limits
ith the Marylar or 28a-f show	Funeral Director	Mo Salti	MORE	Saltimore 10t. Zip Code	100.0	Citizen of What Count	1 ☐ Yes 2 No
3a or	Ö	9615 TENTH	AUE	21234	109. 0	USA	u <b>y</b> r
death	nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		Decify Yes or No-	14. Race - America	
il K i 3-0030 within 72 hours after death with the Maryland ene. then "naturel; or items 23e or 28e-f show the Madical Examinar must be notified at	b	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	o nicari, etc.)	Specify: U	-11TE
n 72 h	Completed	15. Decedent's E (Specify only highest gr	rade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life, DO NOT use retired)	king 16b.	Kind of Business/Ind	lustry
e filed withir II Hygiene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAKER	1	KESIDEN	CE
0 0 0	To Be (	17. Father's Name (First, Middle, Las	Tock	18. Mother's Nam	ne (First, Middle, Maide		
VICE Y 10 42 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship		19b. Mailing Address (Street and Number or Ru 9615 TENTH AVE.	Raltine R		
is 1 and of Healt		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of netery, crematory or other place)		ocation - City or Tox	
Pages ment of ant: if it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State MoR	RELAND MEmorial 22.	2006 10	arkuille,	mD
permit. Pages 1 a Department of Her Important: if Item	Suc	21. Signature of Funeral Service Lice	ensee	22. Name and Address of Facility  EVANS FUNERAL (	8	1800 HAR	FORD 100,
_		23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the death.	Do not enter the mode of dying, such as cardiac		arkville, 11	Approximate
Physicia		Immediate Cause (Final disease or condition				ļ	Interval Between Onset and Death
/Medica		resulting in death)	a. RESPINATE	by FAILURE	Cit.		
/Medica Examine		THE THE REST WAS A SHEET AND A STATE OF	Due to (or as a consequent	L HEMATOMA	A. F. T. T.	4	8 House
Examine	r	THE THE REST WAS A SHEET AND A STATE OF	Due to (or as a consequent by Due to	E HEMATOMA		- 4	9 Hours
executed no and in-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b SUBDURA	L HEMATOMA	vel?	- 1	9 Hours
executed no and in-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence.	L HEMATOMA	well	- !	9 Hours
executed no and in-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent of d.	nce of):	well	23d. Date of deliver	3 Hours
executed no and in-transit	ical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	nce of):	well	23d. Date of deliver Month	ry Day Year
executed no and in-transit	by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a consequent of the consequent	nce of):		Month (	Day Year
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to (or as a consequent of the consequent	nce of):    Continue of   Cont	1 ☐ Yes 24a. Was an autopsy	Month  o use contribute to the  2 No 3 □ Proba  24b. Were autop	Day Year e cause of death?
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	b. Due to (or as a consequent of the consequent	nce of):    Continue of   Cont	1   Yes  24a. Was an autopsy performed? 1   Yes 2   2   2   1	Month  o use contribute to the  2 No 3 □ Proba  24b. Were autop	Day Year e cause of death? abiy 4 Unknown
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	o Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or as a consequent of the consequent of	nce of):    Cotton:   Cott	1 Yes  24a. Was an autopsy performed?  1 Yes 2 2 1 h	Month  o use contribute to the 2 No 3 Proba  24b. Were autoprior to comdeath? 1 Yes	Day Year  e cause of death?  ably 4 Unknown  by findings available opletion of cause of  2 No
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Due to (or as a consequent of the consequent of	nce of):    Comparison of the content of the conten	1   Yes  24a. Was an autopsy performed? 1   Yes 2   2   2   1	Month  o use contribute to the 2 No 3 Proba  24b. Were autoprior to comdeath? 1 Yes:	Day Year  e cause of death?  ably 4 Unknown  by findings available opletion of cause of  2 No
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of Due to	nce of):    Sy   eath   3   Ectopic pregnancy   th   5   Other (specify)	24a. Was an autopsy performed 1 Yes 2 1 N N N N N N N N N N N N N N N N N N	Month  o use contribute to the 2 No 3 Proba  24b. Were autopprior to corredeath? 1 Pes  6 Other (Specify, ury occurred	Day Year  e cause of death?  ably 4 □Unknown  sy findings available apletion of cause of  2 □ No
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	nce of):    Sy   eath   3   Ectopic pregnancy	24a. Was an autopsy performed?  1   Yes 2   No.    th (Check only one)   Yes 2   No.    ome 5   Residence    28d. Describe how inj  FELL 0:JT    28f. Location (Street in City or Town, Sta	Month  o use contribute to the 22 No 3 Proba  24b. Were autoprior to comdeath? 1 Yes: 6 Other (Specify, ury occurred	e cause of death?  ably 4 Unknown  by findings available opletion of cause of 2 No  Route Number,
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	nce of):    Sy   eath   3   Ectopic pregnancy   th   5   Other (specify)	24a. Was an autopsy performed; 1 yes 22 \( \text{N} \) th (Check only one) ome 5 \( \text{Residence} \) Residence 28d. Describe how inj \( \text{FELL 0:JT} \) 28f. Location (Street in City or Town, Street in City or Town, Street in City or Town, and due to the caused	Month  o use contribute to the 2 No 3 Proba  24b. Were autoprior to condeath? 1 Yes:  6 Other (Specify, ury occurred  or BED  and Number or Rural (6) PALTI ME  \$ 3 and manner as \$ 4 and manner	e cause of death?  ably 4 Unknown  by findings available opletion of cause of 2 No  Route Number,
yeicien: The law requires that the death certificate be executed to yeicien: The law requires that the death certificate be seen signed by the attending physicien and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	nce of):    Sylicity	24a. Was an autopsy performed;  1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2	Month  o use contribute to the 2 No 3 Proba  24b. Were autoprior to condeath? 1 Yes:  6 Other (Specify, ury occurred  or BED  and Number or Rural (6) PALTI ME  \$ 3 and manner as \$ 4 and manner	e cause of death?  e cause of death?  ably 4 Unknown  by findings available apletion of cause of  2 No  Poute Number,  Company and the cause(s)
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	act of):    Section   Part   P	24a. Was an autopsy performed;  1 Yes 2 2 1 1 Yes 2 2 1 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2	Month  o use contribute to the 2 No 3 Proba  24b. Were autoprior to condeath?  1 Yes:  6 Other (Specify, ury occurred  CF BED and Number or Rural (e)  s) and manner as stand place, and due to plate signed (Month, Date signed (	Day Year  e cause of death?  ably 4 Unknown  by findings available apletion of cause of 2 No  Pour Number,  Company at the cause(s)  Day, Year)
requires that the death certificate be executed trequires that the death certificate be executed to require the standard physicien and should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent of the consequent of	nce of):    Sylvant   All   Al	24a. Was an autopsy performed to the Canal	Month  o use contribute to the 2 No 3 Proba  24b. Were autoprior to condeath?  1 Yes:  6 Other (Specify, ury occurred  CF BED and Number or Rural (e)  s) and manner as stand place, and due to plate signed (Month, Date signed (	Day Year  e cause of death?  ably 4 Unknown  by findings available apletion of cause of 2 No  Pour Number,  Company at the cause(s)  Day, Year)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Yo the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consequent of the consequent of	act of):    Section   Part   P	24a. Was an autopsy performed to the Canal	Month  o use contribute to the 2 No 3 Proba  24b. Were autoprior to condeath?  1 Yes:  6 Other (Specify, ury occurred  CF BED and Number or Rural (e)  s) and manner as stand place, and due to plate signed (Month, Date signed (	Poure Number,  Poure Number,  Poure Number,  Poure Number,  Poure Number,  Poure Number,  Poure Number,  Poure Number,

			For State Registrar		State o	f Maryla	nd / Dep <i>Ce</i>			lealth a Death	ind M	ental Hy	giene	200	6	303	398
	Physic		1. Decedent's Name (First, N	iddle, Last		3 a Ke						2. Date of De Month Sept			r	3. Time of 9; 34	
	/Medi Examir		4a. Facility Name (If not instit			mber)	*		Town, or		f Death		4c.	County of De	-0		
	Funeral Director		5. Social Security Number 219 40 0364		х ]м 2 <b>)</b> б г	7. Age (In yrs	s. last birthday Yrs.	Months Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D	rth ay, Year) 1 C(4	9. B MA.	irthplac Country RYL	e (State or ND	r Foreign
	r 28a-f show	ctor	Usual Residence of Decedent  10a. State  10b. Col				City, Town or L							·	10d.	Inside Cit	•
	h with the 23s or 28	ai Dire	311 Magne	lia	AVU	nue		10f. Z	p Code	0				zen of What (	Country	?	
9036	within 72 hours after death with the Maryland sne. shen "natural", or Items 23a or 28a-f ehow he Macical Examinar coust be notified a	Completed by Funeral Director	11. Marital Status  1 Never Married 2 3 Widowed 4 Divo		12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	10	U.S. 13.	Was Deci If Yes, sp 1  Yes			in? (Spec , Puerto F	city Yes or No lican, etc.)		14. Race - Ar Black, Wi Specify:			
21215-0	s within 72 hours jiene. r than "natural" the Madical Ex	ompietec	15. Dece (Specify only hi Elementary/Secondary (0- 11th grade			I-4or 5+)		dent's Usi kind of w DO NOT	ork done d use retired	during most  )	of workin	g		nd of Busines	s/Indus	try	
yland 2	ould be filed I Mental Hygid harked other	To Be C	17. Father's Name (First, Mid CLEMEN BROW	N	5					18. Mother	BLE (	(First, Middle					
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within to fleeth and Mental Hygiene. If flem 27 is marked other than or other traumatic event, the Mental fleether than the flee		19a. Informant's Name/Relate Calvin Faker 20a. Method of Disposition	/Son			1970345	2 Pert	trid	go Bd	E:		r. N	Town, State	1 21	235	
Baltimo	permit. Pages Department of i Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe 21. Signat → of Fune of Sen	r (Specify)	1		ING MEM	ORIAI 2. Name a WILL I	PAR	K	09-30 N_COI	MMUNIT	BALI Y FUN	TIMORE, NERAL E	MA HOME	RYLAI	• <u>ND</u>
WIE 8760,	Physician /Medical Examiner  the priightaust	dical Examiner	23a Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o, or somplication of the control of	Due to (	or as a conse	vasc of aquence of):	lar	acci		ardiac or	respiratory a	arrest,		In	pproximate erval Betw nset and D	veen
OL GER	that the death certific ed by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2		irth 2 □Fe≀ ant at time of	tal déath 3 [	⊒Ectopic p ⊒ Other (s					2	3d. Date of d Month	eliv <i>e</i> ry Da	y Y	ear
rds, P	9 <u>10</u> 9	ρ	Part II. Other significant con	ditions cor	ntributing to de	eath but not re	sulting in the u	nderlying	cause give	en in Part I.			tobacco us	se contribute		,	eath? / nknown
Vital Records,	ela has	e Completed	25. Was case referred to me	tical					2	26 Place	of Doath	24a. Was auto perfo 1 Yes	psy ormed? 2 No	24b. Were a prior to death?		findings a etion of ca	vailable use of
Division	ing Phys n. After this funeral di	Certification: To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pe 2 Accident	nding estigation		npatient 2 [ of Injury h, Day Yeer)	28b. Time of Injury		28c. Injury Work	or: 4 🗆 Nur	sing Hom		dence 6	□Other (Sp	ecify)		
Divis	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the in the the thing of the completely filled in by the completely filled in the the completely filled in the complete		4 ☐ Homicide de	uld not be ermined	buildir	ng, etc. (Spec						City or To	wn, State)				er,
	To the Hosp vithin 24 hou To the Fune completely fi	Medical	(Check only 2 Medi	cal Exami	ner: On the ba	best of my krasis of examination of examination of the stated.	nowledge, deat nation and/or in	vestigation	n, in my op	oinion, deat!	place, ar occurred	nd due to the	date and	place, and du	e to the	cause(s)	
	5 1 2 2	-	29b. Signature and title of cer	PA	ice 1	10			c. License	00	1		sep	+ $23$	im, Day	, Year) 006	
	5 Sta	ite	30. Name and address of per	Price	e MD	e of death (Ite		tanove	1 St.	Bal	TIMO	re, 1	10				
	Registr	ar	₩ [	LA A P	100	San San	15	2844	10								

			ricas	State of Ma	ndond /	Deportment of I	. Ensure A	lontal live	Are Legi	Die.	
			1 - State	State of Ma	iryiand /	Department of I	nealth and IV Death			06	30399
			Registrar  1. Decedent's Name (First, Middle,	Last)		Oertificate of	Dealli	2. Date of Dea	Reg. No.		3. Time of Death
	Physic		Charles	W. Blocking	er In			Month Septemb	per 21,	2006	6:00PM
	/Medi Exami		4a. Facility Name (If not institution,		مال وت		or Location of Death	осресии	4c. County		0 001
			Stella Maris Nu	rsing Home		Time	onium		Bal	Ltimor	e
	Funeral		5. Social Security Number	1XIM 2FF	(In yrs. last t	Months Days		8. Date of Birtl (Month, Da)	/ Year)	9. Birthple Counti	ace (State or Foreign
	Director		217-12-0510 Usual Residence of Decedent	200 111 201	34	Yrs.		Sep. 5,		Mary	land
	land ow		10a. State 10b. County		10c. City, To	wn or Location				10	d. Inside City Limits
	Man	ţ	MD N/	, A		Baltimo	re				1 XYes 2 ☐ No
	or 284	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Counti	ry?
	23a	Funeral Director	2747 Washingtor	Blvd., Apt	. 3		21230		United	State	S
	er dez	nue	11. Marital Status	12. Was Decedent E Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	e - America ck, White, et	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1X Yes 2 □ N If Yes, Give Year or Dates:	∘ MMTT	1 ☐ Yes 2 No	Specify:		Specif	w Whi	te
9	within 72 hours after death with the Maryland ene. then "netural; or items 23s or 28s-f show the matilied at	ed	15. Decedent's	Education	16	a. Decedent's Usual Occur	pation		16b. Kind of B	usiness/Indu	ıstry
215	hin 7.	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5-	<b>-</b> )	<ul> <li>Decedent's Usual Occup (Give kind of work done life. DO NOT use retire</li> </ul>	during most of works d)	ng			,
2	ed will	Completed	6			Truck Dri	ver		Fr	eight	
pu	be fill d oth	Be	17. Father's Name (First, Middle, La				18. Mother's Name			18)	
<u>Ş</u>	d Men	은	Charles W. Bloc				l	asina Me			
Ma	d 2 st th and 7 ie n treun	1 5	19a. Informant's Name/Relationshi			b. Mailing Address (Street			r, City or Town,	State, Zip C	Code)
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It has 23 or 28a-1 ehow tem 27 is marked other than "netural", or items 23a or 28a-1 ehow other treumatic event, the Madical Exeminer must be incliffed at	3	Louise Etner - Co	ompanion	20b. Place	747 Washingt of Disposition (Name of	on blvd.,	Apt. 3	, Balti 20c. Location -	City or Tow	MD 21230
ē	ages ent of nt: if i	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	West	ay, crematory or other pla Arundel	ce)				
ij	permit. Pages: Depertment of Findortant: if Ite eny injury or of page.	1	21. Signatur of Funeral Service Li	conges V	Orem	22. Name and Addre	9-28- ess of Facility Am	2006 rose Fu	Odento ineral F	n, MD Jome,	Inc.
ä	en en per		asstremen		N	1328 Sulpl	hur Spring	g Rd., A	rbutus,	MD 2	1227
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused to	the death. Do	not enter the mode of dyir	ng, such as cardiac o	or respiratory arr	est,	1	Approximate nterval Between
	Physician	0.0	Immediate Cause (Final disease or condition	LUNG CA							Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a		9 of):					
	Examine:	١	Sequentially list conditions,	b. — Due to (or as a	000000000000000000000000000000000000000						
	2 1 E	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	3 (1):					
,	be executed	Ехаг	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):					
760,	0 % 0	cai		d							
89	certificat Iding phy Ise as th	Jed	IF FEMALE:								
Box	ath ce ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 □ Live birth 2		h 3 Ectopic pregnance	y			e of delivery	
	g o g	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown	ime of death	5 Other (specify)			Мо	ıın g	ay Year
P.0	res that the signed by be detected	F.	Part II. Other significant condition	s contributing to death but	not resulting	in the underlying cause give	en in Part I.	23e. Did tol	bacco use conti	ribute to the	cause of death?
Records,	requires that the een signed by th hould be deteche	Completed by Physician/Med			·	, , ,					oly 4 📆 Unknown
Ö	≥ ० ७	ete						24a. Was a	n 24h \	Nere autons	sy findings available
Re	The lav ate has page 2	E						autops	med?	leath?	by findings available of cause of
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death	☐ Yes :		☐ Yes 2	LI NO
× ×	Physician: this certific ral director,	2	1 ☐ Yes 2 X No	Hospital: 1  Inpatien	t 2□ER/0	utpatient 3 DOA Oth	er: 4 Nursing Hor	ne 5 🗆 Reside	ence 6 XIOth	or (Specify)	HOSPICE
Division of	nding P eth. r: After t e funera	ë	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury 28c. Injury Wor		8d. Describe ho	ow injury occurr	ed	
isio	ttend deeth stor: /	icat	2 Accident investiga 3 Suicide 6 Could no	be One Class of Inius	. At bassa 6		Yes 2 □No	206 1 100			
Οį	lor A after Direction by	Certification:	4 ☐ Homicide determin	building, etc.	(Specify)	arm, street, factory, office	-	28f. Location (St City or Town	reet and Numb 1, State)	ar or Hurai F	Houte Number,
	To the Hospitel or Attending P within 24 hours after deeth. To the Funerel Director: After i completely filled in by the funera		29a. Certifier 1X Certifying	Physician: To the best of	my knowledg	ge, death occurred at the tir	ne, date and place, a	and due to the ca	ause(s) and ma	nner as stat	ed.
/	he Ho n 24 i he Fu	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner state	examination a	nd/or investigation, in my o	pinion, death occurre	ed at the time, d	ate and place, a	ind due to th	he cause(s)
	To the within to the comp	×	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed		,
			/			D4	3725		9/2	2/06	•
	4+1		30. Name and address of person when the second seco	•	,						
			DR. TARIQ MAHN 31. Date filed (Month, Day, Year)	100D 2300 D	Signatura	VALLEY RD.	TIMONIUM,	MD 210	93		
	Sta Registr		SEP 2 6 2006	32. Registrar	J. Joje						
		-									

SEPTEMBER 21, 2006 6:00 p.m.

CHARLES BLOCKINGER

			1- For Amend #19b Per FH 226 Per Verb 5859 9/26/06 JH Certificate of Death	d Mental Hy	giene Reg. No. 20	06	30400
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Do Month	eath Day	Year	3. Time of Death
	/Medic		Clifford J. Bauer	9-22-			6:30 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. County	of Death	
-	Funeral		815 South Ponca Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 F		rth	9. Birthp	lace (State or Foreign
ш	Director		212-34-0424 MIM 2 F 70 Yrs. Months Days Hours M	04-28	ay, Year) -1936	Md	ntry)
	D .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
	Aanyia F sho	ō					1  Yes 2 No
	the 128a-	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of V	Vhat Cour	itry?
	h with	Funeral Director	815 South Ponca Street 21224		USA		•
	death	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No			an Indian,
36	or the	by Fu	1 □ Never Married 2 □ Married 1 E Yes 2 □ No If Yes, Give 3 □ Widowed 4 ☑ Divorced 1 □ Yes World 1 □ Yes 2 □ No Specify:	Jores Fridain, Gro.,		Whi	
Ö	hours tural'	q pe			16b. Kind of Bu		
15	n na	plet	(Specify only highest grade completed)  (Specify only highest grade completed)  (Give kind of work done during most of the boundary (A) (A) (A) (A) (A) (A) (A) (A) (A) (A)	working	160. Kind of Bu	isiness/inc	dustry
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or ttems 23a or 28a-f show ont, the Medical Examinat must be molified a	Completed	Elementary/Secondary (0-12)  12  College (1-4or 5+)  Pipefitter		Steel	L Mf	g.
pu	should be filed withir and Mental Hygiene. s marked other than umatic event, the M	Bec	17. Father's Name (First, Middle, Last)  18. Mother's N	Name (First, Middle	, Maiden Surnam	Θ)	
yla	2 should be f and Mental I is marked of raumatic eve	P	Clifford Bauer Kathe	erine Re			
Maryland		0	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street of Number or</i>				
	item 27 other tra		Candee Figiel (neice) 160 Wilson Claker  20a. Method of Disposition (Name of	Date Ce	20c. Location -		
nor	e = 5		1 Burial 2 TCremation 3 Removal from State	25-2006		•	
altimore,	permit. Pag Department Important: I any injury o						
ñ	Dep Imp any		21. Signatura Actions and Address of Facility  Bradley-Ashton	F.H.P.A	·Balti	bM.	21222
	•		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	Į.	Immediate Cause (Final disease or condition a with cerebral vascular of	uciden	<i>t</i>		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
н	Zaminer	_	Sequentially list conditions, b. Due to (or as a consequence of)				
	nsit A	Examiner	cause. Enter Underlying Cause (Disease or injury				
Ć,	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	ate be physicia the bur	edical	d				
9	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Med	IF FEMALE:				
Вох	eath certific attending pl	Physiclan/M	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy		23d. Date Mor	e of delive	ry Day Year
0.	he de	ysic	1  Yes 2 No 9 Unknown 5 Other (specify) 9 Unknown		6		,
Φ.	that the de led by the a detached		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1	tobacco use contr	ibute to th	e cause of death?
ds	n signe	d by	invasire sanamons cell corcinoma	1 🗆	Yes 2 □ No	3 Prob	ably 4 Ninknown
Vital Records,	law requir as been si 2 should l	Completed	0	24a. Was		Vere autor	osy findings available
Re	The la	mo		— auto perfo 1 ☐ Yes	ormed? d	eath?	npletion of cause of
Ita	ician: Th certificate rector, pag	BeC		Death (Check only			<b>A</b>
of V	Physician: r this certific ral director,	2	1 Yes 2500 Hospital: 1 Inpatient 2 ER/Outpatient 300A Other: 4 Nursing	g Home			)
no O	ding P h. After 1 funera	ion:	27. Magner of D ath 28a. Date of Injury 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. escribe	how injury occurre	∍d	
Division	tent deat tor; the	icat	2 Accident investigation M 1 Yes 2 No Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f Location /	Street and Numbe	r or Rura	Route Number
Di∨	after after Direct	Certification:	4 Homicide determined determined building, etc. (Specify)	City or To	wn, State)	, Or 11072	rioute rumber,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the	cause(s) and man	nner as st	ated.
	he Hc in 24 he Fu	edical	one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ccurred at the time,	date and place, a	nd due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed		
,	1		Maron Baleuser M.D. D0055157		9/25/	200	6
	5	\	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHARON BALANSON 10 N. Greene St	Baltin	one MD	2	1201
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2006				

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2	0	0	6	3	0	4	0
---	---	---	---	---	---	---	---

		1- For State Registrar		Ce	ertific	ate of	Death			F	Reg. No.	2UU	16 3046
Physici		1. Decedent's Name (First, Middle,La								. Date of De	ath		3. Time of Death
Medical Exami	ner	James A. Bull	ock							Septemb	er 23, 2006	rear	1150 hrs
		4a. Facility Name (if not institution, g	ve street and nun	nber)		4	b. City, Town, o	r Location				ty of Deat	h
		1015 Cedarcroft Road					Baltimore						
Funeral		5. Social Security Number 6. 8	Sex	7. Age (In yrs	last birt	hday)	If Under 1 Ye			8. Date of B	irth(MM/DD/YY	YY) 9. Bi	rthplace (State or
Director		218-64-4611	M 2 F	51		Yrs.	Months Da	ys Hours	s Min.	03-2	3 <b>-</b> 1955	Forei	gn ountry) <b>M</b> D
		Usual Residence of Decedent											
any	ı	10a. State 10b. County		10c. Cit	y, Town	or Location	on						10d Inside City Limits
nd how	_	MD		В	alti	imor	e City						1x Yes 2 No
Maryland 28a-f show any d at once.	용	10e. Street and Number		<u> </u>			10f. Zip Code			- 1	10g. Citizen of	What Co.	
e Ma or 28	Director		C D.:	1						1		· · · · · · · · · · · · · · · · · · ·	anti y :
215-0036 be filed within 72 hours after death with the Maryland nntal Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.		1015 A Cedarc	12. Was Dece			L 40 M	21212				USA		
ath w tems	Funeral	1 Never Married 2 Marrie		ces?	0.8		Decedent of H s, specify Cuba					ice - Amei hite, etc.	rican Indian, Black,
er de , or i	Fu		1 Yes	2 No			o√2 \						
rs afte rral"	ð	15. Decedent's Education (Specify	or Dates:	Tetila	1111		Yes 2X No			d. d	Specif	11 11	ite
hour natu	ompleted	Elementary/Secondary (0-12)	College (1-				st of working life				16b. Kind of	Businessi	rindustry
36 in 72 han lical	ble	1 2	2	40(0+)		C	m						
with with her t	E	17. Father's Name (First, Middle, Las			<u> </u>	ser	vice T				MBC Maiden Surnar	Tech	nologies
15. filed il Hy, ed ot t, the	Be C	James G. Bull						_				ne)	
		19a. Informant's Name/Relationship		•	10	Mailing	Address (Stre			. Dre			7: 0:1)
MD 2 d 2 shou fth and h n 27 is n	٩	1 1	21	athor									
, M and 2 saith em 2 raun	-	James Bullock  20a. Method of Disposition	, JIF	1 20h	Place	of Disposit	ion (Name of ce	Siey	Ka.	oate	ldalk,	MD D City or	Z 1 Z Z Z Town, State
S F S S F S	- 1	1 Burial 2 X Cremation 3	Removal from	m State		ory or other		Sittete: y,	·	Jaila	200. Localio	II - City Oi	Town, State
imore, MD 2121 Pages I and 2 should be fi ment of Heatth and Mental tant: If item 27 is marked or other traumatic event,		4 Donation 5 Other Specif		Ва	yvi	ew (	Cremat	ory	9-2	6-06	Balt:	imor	e, MD
Baltimore, MD 2 permit Pages I and 2 shoul Department of Heath and M Important: If iten 27 is m injury or other traumatic.	1	21. Signal of egif Fungral Service Lice	nsee			22. Na	ame and Addres	s of Facility	Bra	dley-	Ashton	n Fu	neral Home
ш адал		agricum	>		<i>(</i>	PA.	2134	Wil.	1ow	Sprin	g Rd.	, 21	222
Physician		23a. Part I Enter the disease, or comfailure. List only one cause on example.		used the deat	th. Do no	t enter the	e mode of dying	, such as c	ardiac or r	espiratory ar	rest, shock, or I	neart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	Hypertensiv	e Atheros	clerotic	Cardio	vascular Di	sease					Death
		or condition resulting in death)	Due to (or as a	consequence	of):								
	اب	Sequentially list conditions,	). 										
	릴	if any, leading to immediate	Due to (or as a o	consequence	OT):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a d	consequence	of):								<u> </u>
outed cuted			I								_		
760, crate be executed the burial - transit	n/Medical	UNPENDED	AMENDED										
Box 68760, death certificate be exemple attending physician and for use as the burial.	ĕ	IF FEMALE:	23c. If yes, or	utcome of pre	gnancy				_	_	23d. Date	of deliver	y
<b>∞</b> ≒ ≘ ≈	au/	23b. Was decedent pregnant in the past 12 months?	1 Live bir			Feta	al death 3	Ectopio	c pregnanc	У	Month	1	Day Year
ath co	Sici	1 Yes 2 No 9 Unknow		nt at time of o	death 5	Oth	er (Specify)				Ĭ		
ne de	Physicia		9 Unknov										
Records, P.O. Box 6: The law requires that the death cert cate has been signed by the attendir page 2 should be detached for use a		Part II. Other significant conditions	contributing to	death but not	resulting	g in the ur	iderlying cause	given in Pa	art I.				the cause of death?
S, F	Completed by	Chronic alcohol abuse								1 Ye	s 2 No	3 Prol	bably 4 🗸 Unknown
v required shoul	į									24a. Was autor			utopsy findings available completion of cause of
Recc The lavicate ha	틹									perfo	ormed?	death?	
n: To		25. Was case referred to medical					26 Plac	e of Death	(Check on		2 110	1 🗸 Ye	es 2 No
/ita sicia is cer iirect	B	examiner?	Hospital: 1 In	patient 2	ER/O	utpatient		Other <sub>4</sub>			Residence 6	Othe	r Scene
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should b	임	1 Yes 2 No 27. Manner of Death	28a. Date o	f Injury		Time of In		ury at Work			how injury occu		Occine
nding th. Af	Certification:	1 V Natural 5 Pending	(Month, I	Day,Year)			1	Yes 2			, ,		
Sicon Atte r dea ecton by th	g	2 Accident Investiga	28e Place	of Injury - At	home fa	ırm street	factory, office			Rf Location (	Street and Nun	abor or Di	aral Route Number, City
Div	힐	3 Suicide 6 Could no determine	t be	,,	,		,, ,	and rig, or		or Town, S		ibei oi ivo	arai Route Humber, City
lospid I hour uner Iy fill		20a Cortifiar		of multiposition	dos des		and and other stime and other						
the II the F plete	ica	(Check only one) 2 Medical Examina											
To To	Medical	29b. Signature and title of certifier	and manner sta	ated			29c Licen						nth, Day, Year)
241	777	11/1 /	10 10	_									
9		Muna Diassi	W, M	7			O.C.	. IVI. C.			Septemb	E1 24, 2	.000
2x		30. ame and address of person who		,	,	444 5	Ct 1 -	D = 141		1004			
	- )		Assistant Med			111 P6	enn Street, E	aitimore	e, MD 21	201			111
S Regis	tate trar	31. Date filed (Month, Day, Year)	2005 32. Reg	strar's Signa	iure 12	An							
PERSONAL PROPERTY.		SEP 2 6	TANDI CO	150 15 P	A. 5"	J. J. J. S. S. S. S. S. S. S. S. S. S. S. S. S.	A Alvano				<del>,</del> .		
OCME 2006	UUT		**		OR	IGINAL							

State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** Beling, 21, 2006 Joseph 1:15pJohn Jr. Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 105 Juniper Circle Linthicum Anne Arundel Co. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ★M 2 ☐ F Director 58 218-44-2469 Dec24.1947 Maryland Usual Residence of Deceder 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ar than "naturel", or items 23a or 28a-f show the Mudical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Md. Anne Arundel Linthicum Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Juniper Circle 21090 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status s filed within 72 hours after de I Hygiene. other than "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Policeman City of Baltimore 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file report of Health and Mental Hytant: If Item 27 is marked oth 17. Father's Name (First, Middle, Last) Be Joseph John Beling, Sr. Veronica Panek ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon H. Beling (sister) 503 S. Lakewood Ave. Baltimore, Md 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 10 H 10 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Sept25, 06 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, 21. Signature of Funeral Service Licenses tembet 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 1201 Dundalk Avenue Baltimore, MD 21222 Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** 2/10011 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy en1100-1 Tyes 2 X No Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation 24 hours after deal 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29c. License number 29b. Signature and title of certifier 255506 MO Highway Paradere Maryland 21125 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9109 Ritchie tren 31. Date filed (Month, Day, Year) SEP 2 6 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene [] [] [

3	0	4	0	3
-				

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** FLORA ESTELLA BLUCHER 22, SEPT. 2006 5:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESTMINSTER
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. CARROLL HOSPITAL CENTER  ${ t CARROLL}$  Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F Months 93 Director 521-58-3355 10/8/1912 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show any injury or other treumstic event, Ite Modical Examinations in Item Intiliar at ¹X Yes 2 □ No Director MD CARROLL TANEYTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3776 ERIN JACOB DR. 21787 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be HARRY J. MYERS MINNIE IZETTA KEEDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA WILHIDE -GRANDCHILD 3776 ERIN JACOB DR., TANEYTOWN, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Donation 5 Dolher (Specify) EVERGREEN MEM.GARDENS 9/25/06 FINKSBURG, MD 21. Signature di Fiureral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD Approximate Interval Between Onset and Death 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cute Physician /Medical Due to (or as,a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, ettending physician Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţoţ in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown r signed by to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 □ hknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 3 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ို 2 | H6 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending м 1 □Yes 2 □No investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 039502 00 3 ame and address of person who impleted cause of death (Item 23a) (Type, Print) East rain st MW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene  $200\,\mathrm{f}$ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Helen Bowers 23,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore RURANO STONERAL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) al Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**XX** Min 212-12-5595 Director 85 Dec\_ Ohio Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits ?7 is marked other then "natural", or items 23a or 28e-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2X No Director MDBaltimore <u>Parkville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3119 Acton Road 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Caucasian Completed by 3XXWidowed 4 □ Divorced "natural", 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Bookkeeper Credit Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Kokinakos Lottie Loskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is eny injury or other traisons. Beverly Ann Condax, daughter 2109 Carlo Court, Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Sept 26, 2006 Baltimore, MD 21. So ature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road, Baltimore, Maryland 23a. Part . Errier the disease shock, or heart failude. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events P.O. Box 68760.⊄ resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has lirector, page 2 s performed 2 No 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 2 DER/Outpatient 3 DOA 1 Inpatient After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred 1 UNatural 5 Pending death investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Dirsc completely filled in by 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 31. Date filed (Most) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 30405 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day Y September 20, 2006 Medical Examiner BARRY 1838 hrs JAY BERLIN 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death University Hospital Baltimore N/A 5. Social Security Number 6 Sex If Under 1 Year | If Under 24Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth (MM/DD/YYYY 9 Birthplace (State or Months Days Foreign Country) Director Hours 220-02-4509 1 X M 58 05/02/1948 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f show MD N/A BALTIMORE 1 Y Yes 2 No must be notified at once. death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 6007 BAYWOOD AVENUE 21209 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Armed Forces? 1 X Never Married 2 White, etc. Married 2 X No Yes Widowed If Yes. Give Year Divorced 1 Yes 2 X No specify: WHITE Specify 15 Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) 2 should be filed within 72 ho hand Mental Hygiene
27 is marked other than "na Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 8 NONE NONE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) SAMUEL BERLIN Be RUTH LIBOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ RUTH BERLIN / MOTHER 6007 BAYWOOD AVENUE - BALTIMORE, MD 21209 ses I and 2 s of Health a If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Pages 1 1 X Burial 2 Cremation 3 Removal from State Department o Important: injury or oth SHAAREI ZION CEMETERY 9/22/2006 ROSEDALE, MD Donation 5 Other Specify 21. Signature of Funeral Service L SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I Enter the disease Part I Enter the disease for complication failure List only one cause on each line Physician Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease a Choking Examiner or condition resulting in death) Due to (or as a consequence of) b Aspiration of Food Bolus Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and tran Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, P. Swallowing disorder; schizophrenia; mental retardation 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 ၉ 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Sep 20, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d Describe how injury occurred Certification: Natural Subject aspirated on food bolus 1750 hrs 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 630 West Fayette , Baltimore, MD within 24 hours a To the Funeral I determined (Specify) Mental Health (State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E September 21, 2006 0 ca 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) SEP 26

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

32. Registrar's Signatur

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Thelma Marie Chamberlin 24, SEP 2006 8:48 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Essex Baltimore 8. Date of Birth (Month, Day, Year MAY 22, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2只F 216-20-3526 81 USA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No N/ABaltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6825 Bank St 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Pence/friend 6915 Conley St Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/25 / 06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc. C. Todd Dring 299 Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cheductive Due to (or as a consequence of): Mas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) liverticularia that initiated events resulting in death) Last Due to (or as a consequence of): Steoperis IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

2 M No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death

Department of important: if any injury or once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23s or 28s-1 show ury or other traumatic avent, Ita Medical Examinar mant be melified at

Be Completed by Funeral Director

burial-transit use as the ŏ signed by the e peeu after death.

Director: After this certificate hes I
in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner Certification: To

Medicai

25. Was case referred to medicat examiner? 27. Manner of Death 29a. Certifier 29b. Signature and

within 24 hours a To the Funeral C filled completely

17 State

Registrar

31. Date filed (Month, Day, Year)

sebastion

2 No

5 Pending

ine of dertifier

investigation 6 Could not be determined

1 Yes

1 Natural 2 Accident

3 Suicide

4 - Homicide

(Check only one)

30 Name

SEP 2 6 2006

address of person

who completed cause of death (Item 23a) (Type, Print) 3023

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

Eautern Arenne Boltimore

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number N 00221

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Bernard Leo Corasa	niti State of Marylar		f Health and Mental H	ygiene	
	Registrar 1 Decedent's Name (First, Middle,Last)	Certificate o	Death	Reg. No.	-2006 3040
Physician/ Medical Examiner	Bernard Leo Co	rasaniti, J		Month Day September 20,	
	<ol> <li>Facility Name (if not institution, give street and num 8365 Hillendale Road</li> </ol>	ber)	4b. City, Town, or Location of Deatl Parkville		lc. County of Death  Baltimore County
Funeral	5. Social Security Number 6. Sex 7	Age (In yrs last birthday)	If Under 1 Year If Under 24Hr		M/DD/YYYY) 9. Birthplace (State or
Director	216-84-7661   1XM 2 F	44 yrs	Months Days Hours Mir	APR 17 1	962 Foreign Country) MD
, h	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca			10d Inside City Limits
ом яну	MD Baltimore	Parkville	tion		1 Yes 2 X No
yland a-f sh t once	10e. Street and Number	- I dikviiic	10f, Zip Code	I 10g Cit	tizen of What Country?
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Out: If item 27 is marked other than "natural", or items 23a or 28a-f show a reother traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	8365 Hillendale Road		21234	log. on	USA
death with r items 23 nust be no uneral	11. Marital Status 12. Was Deceded 1 Never Married 2 Married Armed Ford		as Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
r dear r mus Fur	1 Yes 3 Widowed 4 X Divorced If Yes, Give Year	2 X No	Yes 2 X No specify:	,	1
irs afti	15. Decedent's Education (Specify only highest grade	completed) 16a. Decede	nt's Usual Occupation (Give kind of	work done 16b.	Specify: White Kind of Business/Industry
.0036 within 72 hour giene. her than "natu . Medical Exar ompleted	Elementary/Secondary (0-12) College (1-4	during m	nost of working life. DO NOT use ref		,
036 Aithin and and and and and and and and and an	12	Sales	Representative	Te	elevision Cable
21215-0036 old be filed within 7 Mental Hygiene. nearked other than nearked to the Medica cevent, the Medica for Be Comple	17. Father's Name (First, Middle, Last)	C		e (First, Middle, Maider	n Surname)
2121 ould be fi Mental J s marked if event,	Bernard Leo Corasaniti,  19a. Informant's Name/Relationship (Type, Print)		Mary g Address (Street and Number or	Hammel Rural Route Number C	City or Town State Zin Code)
MD 2 ad 2 shou alth and 1 m 27 is r aumatic	Mary Corasaniti - mother		Hillendale Road		
e, N l and Health r tran	20a. Method of Disposition	20b. Place of Dispos	sition (Name of cemetery,		. Location - City or Town, State
altimore, mit. Pages lan epartant of Her portant: If ite lury or other tr	Burial 2 X Cremation 3 Removal from  4 Donation 5 Other Specify:		ke Crematory 9/2	20/2006 Be	eltsville, MD
alti mit partm ports ury o	21 Signature of Funeral Service Licensee	<sup>2</sup> C/	AFA, Stephen D. 1 17 Green Pasture	 Lohrmann, F	PA
	23a. Pan I. Enter the disease, or complications that cau				PA Towson, MD 21286
Physician /Medical	failure. List only one cause on each line.			or respiratory arrest, sir	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Methado Due to (or as a condition resulting in death)	one and cocaine in onsequence of):	ntoxication		Death
North Control	Sequentially list conditions, b				
iner	if any, leading to immediate Due to (or as a course. Enter Underlying Course	onsequence of):			
ed nsit <b>Examiner</b>	(Disease or injury that initiated events resulting in death) Last Due to (or as a context of the	onsequence of):			-
evecul an and al - tra	X UNPENDED X AMENDED	:+cm#1 220 27 20c	-f,perME,g860, 10/19	) /OC TITE	
60, ate be shysici ne buri	IF FEMALE: 23c. If yes, ou	ILCOII#1,23d,27,20d	-1, penue, good, 10/19	23	3d. Date of delivery
68760 certificate nding phy se as the b	23b. Was decedent pregnant in the past 12 months?	at at time of death	etal death 3 Ectopic pregn	ancy	Month Day Year
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the edical Certification: To Be Completed by Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	3 _ 0	ther (Specify)		
O. E. hat the ed by the letached	Part II. Other significant conditions contributing to d	death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ires tha signed be det				1 Yes 2	No 3 Probably 4 Unknown
of Vital Records, ng Physician: The law require. Wher this certificate has been signeral director, page 2 should be n: To Be Completed				24a Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ecc he lav ate ha				performed?	
al Rian: 1	25. Was case referred to medical examiner?	····	26 Place of Death (Check	only one)	
F Vita Physicia or this co all direc	1 ✓ Yes 2 No	patient 2 ER/Outpatien			lence 6 🗸 Other: Scene
n of ding Ph	27 Manner of Death  1 Natural 5 Pending  28a. Date of (Month, I)  Find O/			28d Describe how inj	jury occurred
SiO Atten r deatl ector: by the	2 Accident Investigation 28e Place		23 am 1 Yes 2 X No	unknown	and Number or Rural Route Number, City
Division or spiral or Attending points after death meral Director: Alfilled in by the fur Certification	3 Suicide 6 X Could not be determined (Specify)	found at home	ot, ractory, office ballating, etc.		β385 Hillendale Road
Hospi 24 hou Funer rely fill	29a. Certifier (Check only 1 Certifying Physician: To the best		rred at the time, date and place, and		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the	one) 2 Medical Examiner: On the basis of and manner sta		ation, in my opinion, death occurred	at the time, date and pla	lace, and due to the cause(s)
- *F °   \$	29b. Signature and title of certifier		29c. License number		. Date signed (Month, Day, Year)
العا	Potullu- Bll	L un	O.C.M.E.	Ser	ptember 21, 2006
252	30. Name and address of person who completed cause Patricia Aronica-Pollak MD. Assistan	of death (Item 23a)  nt Medical Examiner	111 Penn Street, Baltimo	re MD 21201	
State		istrar's Signature		.0, 1410 2 1201	
Registrar	SEP 2 6 2006	1. 1. A.	all mentions		

State of Maryland / Department of Health and Mental Hygiene 2006 30408 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:15 PM M September 24, 2006 Lucile Cherniavsky /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Broadmead Health Care Center Baltimore Cockeysville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/18/1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🔄 F 85 Yrs. NY Director 098-14-6865 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ar then "neturel", or items 23e or 28a-f show, the Medical Examiner must be notified at 1 Yes 2 No Funeral Directo MD Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 13801 York Rd United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify Specify: Caucasian þ 3. ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Non profit Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Assistant organization 4 1 and 2 should be filed v Health and Mental Hygie tem 27 is marked othar ti 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tillie Apar Barnett Javitz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lucile Cherniavsky/Self 13801 York Road Apt. J 12 Cockeysville, MD 21030 Health tem 27 Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ott 27 Sep 1 ☐ Burial 2 Scremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2006 \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives do MD 1443 | 8717 Green Pastures Drive Baltimore, Maryland Keller 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NCKEA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 (2 No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 / Irsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 2006 32. Registrar's Signature 6 State Registrar

# Please Type or Print in Black Indelible Ink

Physicia cal Examir	117/	- For State  Registrar 1, Decedent's Name (First, Middle,Last)	ficate of Death	2. Date of De	Reg No. 20	0.6 3.04 Sime of Death
	ner	Steven D. Cooke			Day Year per 22, 2006	1900 hrs
		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital	4b. City, Town, or Loc Rosedale		4c. County of De Baltimore C	County
Funeral Director		5. Social Security Number 213-96-5961 6. Sex 7 Age (In yrs. last 3	Martha Day		n13,1970 e.	Birthplace (State or reign CountMaryland
Maryland 28a-f show any d at once.	_		own or Location iddle River			10d Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once	Dire	10e. Street and Number 208 1C Middleway	10f. Zip Code 21220		10g Citizen of What CUSA	country?
ter death with	Fune	11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No	13. Was Decedent of Hispar If Yes, specify Cuban, Mo	exican, Puerto Rican, etc.)	White, etc	nerican Indian, Black, Thite
	Completed by	15. Decedent's Education (Specify only highest grade completed) 16. Elementary (Secondary (9.12) College (1.4 or 5h)	6a Decedent's Usual Occupation during most of working life. DO Roofer	(Give kind of work done	16b. Kind of Busine	
oe filed withintal Hygiene ked other themet	Be Comp	17. Father's Name (First, Middle, Last) Parker Cook		Mother's Name (First, Middle, Nancy Little		
Pages I and 2 should be finent of Health and Mental I ant: If item 27 is marked or other traumatic event,		19a. Informant's Name/Relationship (Type, Print ) Parker Cook /father	19b. Mailing Address (Street ar 3047 Whitefo	ord Road Py	lesville	MD 21132
permit Pages I an Department of Hea Important: If iter injury or other tra	J	1 Burial 2 K Cremation 3 Removal from State Ba	ce of Disposition (Name of cemete matory or other place) Yview Cremato	ory 9/25/06	Baltimo	ore MD
permit Departm Departm Importa injury or		21. Signature of Funeral Service Licen e  23. Par I. Enter the disease, or implications that caused the clean. Di		Funeral H		
Medical xaminer		failure. List only one calls on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		The section of the spiratery di	Test, shock, of fleat	Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
icate be executed physician and the burial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
ate be exemple sician of burial -	Medical	X UNPENDED AMENDED item#23a,2	7,28a-f,perME,g860,	10/2/06 TT		
e death certificate the attending phy ed for use as the	Physician/M	IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3	Ectopic pregnancy	23d. Date of deliv Month	very Day Year
atte for 1	-	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause give	n in Part I 23e Did	tobacco use contribute	
res that the death signed by the atte be detached for t	Š			1		to the cause of death?  Probably 4  Unknown
he law requires that the death ate has been signed by the atte age 2 should be detached for t	Š			1 Ye	es 2 No 3 F s an 24b Were prior prior death	Probably 4  Unknown autopsy findings available to completion of cause of
ian: The law requires that the death certificate has been signed by the attector, page 2 should be detached for the core.	e Completed by	25 Was case referred to medical	26 Place of I	1 Ye 24a Was autc perf 1 Yes  Death (Check only one)	es 2 No 3 F s an 24b Were prior prior death	Probably 4  Unknown autopsy findings available to completion of cause of
Physician: The law requires that the death rr this certificate has been signed by the attendictor, page 2 should be detached for the	Completed by	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2  EF	26.Place of I	1 Ye 24a Was autc perf 1 Ye Yes  Death (Check only one)	es 2 No 3 F s an 24b Were ppsy prior ormed? 2 No 1  Residence 6 Ot	Probably 4  Unknown autopsy findings available to completion of cause of
Attending Physician: The law requires that the death reach extent. After this certificate has been signed by the attempt the funeral director, page 2 should be detached for the control of the control o	To Be Completed by	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2  EF  27. Manner of Death  Natural 5 Pending Investigation  1 Accident  Natural 5 Pending Investigation  1 Accident	26 Place of IR/Outpatient 3 DOA Oth 8b. Time of Injury 28c. Injury at 1 Yes	1 Yes  24a Was auto perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the perfinition of the performance	es 2 No 3 F s an 24b Were prior ormed? 2 No 1   Residence 6 Ot how injury occurred	erobably 4  unknown autopsy findings available to completion of cause of ? Yes 2 No
4 hours after death 4 hours after death **imeral Director: After this certificate has been signed by the atter of filled in by the funeral director, page 2 should be detached for the	Certification: To Be Completed by	examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 4 Homicide  Natural 5 Pending Investigation Find 9/22/2006 F  28e. Place of Injury - At home (Specify) found in 1999.	26. Place of I R/Outpatient 3 DOA Oth 8b. Time of Injury 28c. Injury at 1 Yes e, farm, street, factory, office build 1 residence	1 Ye 24a Was auto perfunction on the perfunction of Town, Middle	es 2 No 3 F  an 24b Were prior ormed? 2 No 1 ✓  Residence 6 Ot how injury occurred  (Street and Number or State) 208 Midd1  RIVER,	erobably 4 Unknown autopsy findings available to completion of cause of 12 Yes 2 No her.  Rural Route Number, City Leway Apt. 1 C
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death  To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for 1	edical Certification: To Be Completed by	examiner?  1  Yes 2 No  No  Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined Coul	26 Place of I R/Outpatient 3 DOA Oth Bb. Time of Injury 28c. Injury at 1 Yes e, farm, street, factory, office build 1 residence death occurred at the time, date a	1 Yes  24a Was auto perful Ves  Death (Check only one)  er4 Nursing Home 5  Work?  28d. Describe  2 X No unk  ing, etc. 28f. Location Middle  and place, and due to the cau ath occurred at the time, date	es 2 No 3 F s an 24b Were psy ormed? 2 No 1  Residence 6 Ot how injury occurred  (Street and Number or state) 208 Middl RIVER, 1	erobably 4  Unknown autopsy findings available to completion of cause of Yes 2 No her.  Rural Route Number, City eway Apt. 1 C tarted. the cause(s)
sspiral or Attending Physician: The law requires that hours after death hours after death neral Director. After this certificate has been signed y filled in by the funeral director, page 2 should be detain the funeral director.	Certification: To Be Completed by	examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 4 Homicide  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	26 Place of I R/Outpatient 3 DOA Oth 8b. Time of Injury 28c. Injury at 1 Yes e, farm, street, factory, office build a residence death occurred at the time, date a for investigation, in my opinion, de 29c. License nu O.C.M.E	1 Yes  24a Was auto perfined to the cause and place, and due to the cause at the time, date auto perfined to the cause at the control of the cause at the cause at the time, date authors.	es 2 No 3 F s an 24b Were prior comed? 2 No 1  Residence 6 Ot how injury occurred  (Street and Number or state) 208 Middl RIVET, see and place, and due to	robably 4 Unknown autopsy findings available to completion of cause of ? Yes 2 No her.  Rural Route Number, City eway Apt. 1 C tarted. b the cause(s)
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death  To the Funeral Director. After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for the funeral director.	Medical Certification: To Be Completed by	examiner?  1  Yes 2 No  1  Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) found in 29a. Certifier (Check only one) 2  Medical Examiner: On the basis of examination and/and manner stated.	26 Place of I R/Outpatient 3 DOA Oth 8b. Time of Injury 28c. Injury at 1 Yes e, farm, street, factory, office build a residence death occurred at the time, date a for investigation, in my opinion, de 29c. License nu O.C.M.E	1 Ye 24a Was auto perf 1 Yes  Death (Check only one)  er Work? 2 X No unk ing, etc. 28f. Location Middle and place, and due to the cau ath occurred at the time, date	es 2 No 3 F s an 24b Were prior ormed? 2 No 1  Residence 6 Ot how injury occurred  (Street and Number or State) 208 Middl River, 1   Just (S) and manner as s and place, and due to 29d Date signed (a)	robably 4 Unknown autopsy findings available to completion of cause of ? Yes 2 No her.  Rural Route Number, City eway Apt. 1 C tarted. b the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 11FM/17&18 per INF. (859 9/29/06, ws
State of Maryland / Department of Health and Mental Hygiene 0 6

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 23, Year September 23, 2006 ROBERT LEWIS CONWAY **Physician** 10:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BRIGHTON GARDENS OF TOWSON TOWSON
If Under 1 Year | If Under 24 Hrs. Baltimore County 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Yrs 122-09-9331 Director 86 Nov 6, 1919 Ohio Usual Residence of Decedent 10b, County 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Exacting must be notified at 1 Yes 2 No Maryland Baltimore County Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 6451 North Charles Street USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) TyYes 2 ☐ No 1 Never Married 2 Married '42-'46<sub>1□Yes 2</sub>No Baltimore, Maryland 21215-0036 Specify: Specify: White à 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Professional Fundraiser Collegiate Funding 17. Father's Name (First Middle Last)
ROBERT B. CONWAY
Frank Conway 18. Mother's Name (First, Middle, Maiden Sumame)
ELEANOR METCALF Be Eleanor Lewis Metcalfo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If itam 27 is m any injury or other traum QDCE. Dr. Abner B. Lall (Pers. Rep.) 414 Northway, Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 9/25/2006 Baltimore, Maryland 21. Signatur / uneral Service / see

Martin D. Lawson

22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road, Baltimore, Maryland 21212

23a. Part. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 21. Signatur / Funeral Sewick See Martin D. Lewyson Approximate Interval Between Onset and Death Immediate Cause (Final Canc 101 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): lending physician are use as the burial Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant atten I for u 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the all 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting the underlying cause given in Part I. þ alment 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 🗹 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Cther: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Can 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN KIMMEL, MD, 6569 North Charles Street, Towson, Maryland 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 6 2006 State Registrar

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
AMEND TTEM#31 perDVR G859,9/26/06, WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Deegan lian 4:26 P M sep 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Manyland Medical Center NIA Balhmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 F 217-80-7251 83 Feb. 24, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location Arbutus 10a State Baltimore 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1015 Downton Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Haas Loretta Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Deegan, daughter 1221 Linden Ave. Arbutus, MD. 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 09-25-06 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physicien and use as the buriat-transit Division of Vital Records, P.O. Box 68760, 🧒 cate has been signed page 2 should be det certificate this After this funeral d within 24 hours after death.

To the Funeral Director: An completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.
Int: If Item 27 ie marked other then "netural; or Iteme 23a or 28a-f ehow

permit. Pages Department of I Important: If Its eny Injury or o

Physician

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Completed by Funeral Director

Be

ျှ

	Immediate Cause (Final disease or condition resulting in death)	Chronic C	bsmchi	re	Pulmonan	y Di	sease	_	Onset an	
i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	quence of):							
ıysıcıan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3 DEctor					23d. Date of d Month	felivery Day	Year
Completed by Physician/Medical Examiner	Part II. Other significant conditions con Congestive Hear	tributing to death but not res	sulting in the underly	ing cau	se given in Part I.	24a	a. Did tobacco  1 Yes 2  a. Was an autopsy performed?  Yes 2 No	No 3 24b. Were prior to death?	Probably 4	Unknown
ge	25. Was case referred to medical				26. Place of Dea			/		
0	examiner?	ospital: Inpatient 2	ER/Outpatient 3F	DOA	1 00		Residence	6 Other (Sr	acorfu)	
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. D=e of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	,	scribe how inju		ecity)	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - At h building, etc. (Special	ome, farm, street, fa	ctory, o	ffice	28f. Loca City	ation (Street ar	nd Number or I	Rural Route Nu	ımber,
medical Certification:	29a. Certifier (Check only one)  1 Certifying Physical Check only one)	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death occu tion and/or investiga	rred at i	the time, date and place my opinion, death occu	, and due irred at the	to the cause(s time, date and	) and manner a d place, and de	as stated. ue to the cause	o(s)
Σ	29b. Signature and title of certifier	sel, in	D	29c. L	icense number 2   8559		29d. Da	te signed (Moi	nth, Day, Year)	b

State

Registrar

firm It foods

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Green

South

31. Date filed (Month, Day, Year)

Street

SEP 2 6 2006

32. Registrar's Signature

#### 06-07110 Laura E. Dusome

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene			
Certificate of Death	Reg No	2006	301

		- For State egistrar		Cei	rtificate of	Death		R	eg No 2	nnc	201.1
Physiciar		I. Decedent's Name (First, Middl	e,Last)					2. Date of Dea	th C	<del>vya</del>	ime of Death
ledical Examin		Laura Eliz	aheth Dus	OTTE				Month Septembe	er 20, 2006	ar (	0530 hrs
		4a Facility Name (if not institution			4	b City, Town, o	r Location of D		4c. County	of Death	
		Stella Maris				Timonium			Baltimo	re County	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	ar If Under 24	4Hrs. 8. Date of Bu	th(MM/DD/YYY)	9. Birthola	ice (State or
Director						Months Day					Maryland
Birector	L	215-10-3283	1 M 2 <b>X</b> F	99	Yrs			November November	11,1900	Country	,)
>		Jsual Residence of Decedent		10- 04	Town or Locati					T 104	Inside City Limits
an *	- 1	10a. State 10b. County  Maryland Ca	rroll		kesvill						Yes 2 No
and sho											Yes 2- No
Aaryland 28a-f show any 1 at once.	Director	10e. Street and Number				10f. Zip Code		1	0g Citizen of W	nat Country?	
th the Maryland 23a or 28a-f sho notified at once		2810 Kaywood	Place A	pt. 9		21784	+	Սո	ited Sta	ates o	f America
with	Funeral	11. Marital Status		cedent Ever in U				( Specify Yes or No		e - American I	Indian, Black,
eath item	<u> </u>	1 Never Married 2 M	arried Armed F	orces?	It Y	es, specify Cuba	in, Mexican, Pu	ierto Rican, etc.)	Whit	e, etc.	
fer d		3 Widowed 4 N Div	orced If Yes, Give Ye		1	Yes 2 X N	o specify:		Specify:	White	e
hours afte	<u></u>	15. Decedent's Education (Spe	or Dates: cify only highest gra	ide completed)		t's Usual Occupa			16b. Kind of Bu	ısıness/Indus	stry
72 ho	eted	Elementary/Secondary (0-12)	College (	1-4 or 5+)	_	ost of working life		e retired)	Raltime	ora Pi	zza Crust
hin hin than than	ā E O		1		Office	Manager	•			oanv	ZZZ CIUSC
d with ther	ξŀ	17. Father's Name (First, Middle,	Last)				18 Mother's N	lame (First, Middle, I			
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	D Be	James W. Ko	ller				Elva (	G. Bennet	t		
212 212 Ment Ment mark	╝├	19a Informant's Name/Relations	hip (Type, Print )	· · · · · · ·	19b. Mailing	Address (Stre	et and Number	or Rural Route Nur	nber. City or Tow	n State Zip	(Code)
MD 21215-0036 2 should be filed within 72 h and Mental Hygiene 27 is marked other than maric event, the Medical	-		_		5588			Sykesvill			′
≥ 5 d d g g	+	Mrs. Rebecca H	arrity	Daughten 20b.		ition (Name of co	emetery.	Date	20c. Location	- City or Tow	n. State 70/
		1 <b>XB</b> urial 2 Cremation	n 3 Removal i	rom State	crematory or oth	ner place)	1				
more Pages 1 nent of H ant: If i		4 Donation 5 Other S	pecify:	Wes	_		- 1	09/25/06			-
Baltimore, permit Pages I ar pertiment of Hea Important: If ite injury or other tr		21. Signature of Funeral Service			22. N	ame and Addres	ss of Facility ${f L}$	oring Bye	rs Funei	al Di	rectors,In
ದ್ ೩೭೬೯	-	Joseph & Ko	lenor 1	KW33	3 87:	28 Liber	ty Roa	d, Randal	lstown.	Mary1	and 21133
Physician		23a/Part I. Enter the disease, or	complications that	caused the death	. Do not enter ti	ne mode of dying	g, such as carda	ac or respiratory arr	est, shock, or he	art Ap	pproximate Interval letween Onset and
/Medical	1	failure. List only one cause Immediate Cause (Final disease		cations of	f multipl	e inimie	S			В	Death
Examiner		or condition resulting in death)		a consequence of		o 121, j 42 20.				_	
		Sequentially list conditions,	b.								
	힐	if any, leading to immediate		a consequence o	of):						
	ĒΪ	cause. Enter Underlying Cause (Disease or injury that initiated	C								
# po ==	Examiner	events resulting in death) Last	Due to (or as	a consequence o	of):						
ecuted 1 and 1 ransit			¬ d		·						
760, cate be execution physician and the burial - trans	n/Medical	X UNPENDED	AMENDED	item#23a	,27,28a-f	perME,g8	60,10/3/0	)6 TT			
8760, tificate be en ng physician as the burial	<b>ĕ</b> [,	IF FEMALE:	o	, outcome of preg					23d Date of	delivery	
68 certific ding se as 1	흔	3b. Was decedent pregnant in the past 12 months?			2 Fe	tal death 3	Ectopic pre	egnancy	Month	Day	Year
Box e death c the atten	ဒ္ဓ	1 Yes 2 V No 9 Uni	known 9 Unkr	nant at time of de	eath 5 Ot	her (Specify)			1		T
that the death certifined by the attending detached for use as s	ᇍ		Ja Colki				-in-a in Dard I	220 Dud to	obacco use contr	ibuta ta tha c	auga of dooth?
P.O.	Š	Part II. Other significant condit	ions contributing	to death but not r	esuiting in the t	inderlying cause	given in Pan I.				
rds, P.O	ᅙ							1 Ye	s 2 No 3	Probably	4 <b>U</b> nknown
rds requ	ompleted							24a Was autop			y findings available = 1 letion of cause of
co e law e 2 s	윈							perfo	rmed?	death?	_
Re The	ပ  -					00 Pi	(5)	1 ✓ Yes	2 No 1	<b>✓</b> Yes	2 No
Division of Vital Records, ral or Attending Physician: The law requirers after death.  The Director: After this certificate has been sited in by the funeral director, page 2 should be an or the funeral director.	a B	25 Was case referred to medica examiner?	Hospital:		1		Other No				
hysi	의.	1 Yes 2 No		Inpatient 2	ER/Outpatient				Residence 6		ene
n of \ding Phy		27. Manner of Death	(Mon	e of Injury th, Day,Year)	28b. Time of I	· · · · · ·	ury at Work?		how injury occur	ed	
tend tend to the t	ertification:	Natural 5 Pend 2 X Accident Inve	ding stigation 8/17	7/2006	12:24 a	m 1	Yes 2 X No	passenge	er of auto	collis	ion
ViS or At her d in by	읩		ld not be 28e. Pla	ce of Injury - At h	ome, farm, stree	et, factory, office	building, etc.	28f. Location (	Street and Numb	er or Rural R	Coute Number, City
Division pital or Attent ours after death ceral Director: filled in by the	팅		rmined (Specify	street				Sykesvil	le, M	Ly Nu. c	oute Number, City Monarch
bon hol	ပြု	29a Certifier	hysician: To the be		lge, death occur	red at the time.	date and place.		-		
To the Hos within 24 h To the Fur completely	<u></u>		miner: On the basis	of examination a							use(s)
To the within To the comple	Medical	29b. Signature and title of certific	and manner	stated.			nse number		29d Date sign		
0		<u> </u>		000	Ā	1	,M.E.				1
NI		Potri (Me	nica -	Tolla	le		, IVI. L.		Septembe	. Z I, ZUUD	<u>'                                     </u>
10,0		30. Name and address of persor		,							
18		Patricia Aronica-Polla	k MD. Assis	tant Medical	Examiner	111 Penn S	Street, Baltir	more, MD 2120	1		
Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signati	ures of	and I					
Registr	ar	SEP 2	6 2006   1	J. J. 182 S	is says						

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 77 (5 12005 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Days

Hours Min. (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Vear 18 M 2 ☐ F Yrs. Director 13 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo BALLIMORE 1609/20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or iteme 23a 4300F Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: W.W.J. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 50x161 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I 104 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 . AG 5705505 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Depertment of Important: If it eny injury or o cemetery, crematory or other place) T⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4. ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign sture of Funeral Service Licensee 48616 SON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dons resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the a page 2 should be detached in 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 28 No 1 Yes 2 No 1 ☐ Yes After this certification Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: Medicai Certification: To 1 ☐ Yes 2 🕅 No 1 🔲 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. ours efter death. neral Director: A filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) eptenber 50 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 MOUNTER W) Boome up Zilor 31. Date filed (Month, Day, Year) 32. egistrar's Signature State 6 Registrar

			For State Registrar	State of Mar			ment of F		d Mer		ne No.20	06	30411	4
ī	Physicia	an	1. Decedent's Name (First, Middle, Las.	,						Date of Death Month	Day	Year	3. Time of Death	
	/Medic	al	FLORENCE G.	EDER		45	Chi Taura o	r Location of D		EPTEMB	ER 20	2006	9:19	1
	Examin	er	4a. Facility Name (If not institution, give MANOR CARE NURS			. 40.					•			
	Funeral		Social Security Number     6. Security Number	x 7. Age (	V LLLE In yrs. last bir		Under 1 Year onths Days	SEDALE If Under 24 Hours	Hrs. 8.	Date of Birth (Month, Day, Ye	BALTI		ace (State or Foreign	n
	Director		220 01 1194	M 2 □ F	89	Yrs.	Days	Hours	SE	PT. 26,	1916		ZLAND	
	land ow II		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	n or Locatio	on					10	d. Inside City Limits	;
	Mary I eh	tor	MD n/a		BALTI	MORE							1 ☐ Yes 2 ☐ No	)
	or 28s	Director	10e. Street and Number				Of. Zip Code			10g.	Citizen of W	hat Count	ry?	
	ath wi	ral	4310 ARIZONA AVEN				21206				USA			
	ltems	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No		13. Was	Decedent of H s, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Puerto Rica	Yes of No- an, etc.)		- America k, White, e		
2-003b	hours after death with the Maryland tural', or Items 23a or 28a-f ehow al Examinal must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 `	Yes 2 XNo	Specify:			Specify:	WHI	TE	
ر ا	2 8 3	Completed	15. Decedent's Edi (Specify only highest grad	scation le completed)	16a.	Decedent's (Give kind	s Usual Occup	eation during most of d)	f working	168	. Kind of Bu	siness/Ind	ustry	
7	within and the state of the sta	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	I .						V W I 1101	_		
N O	filed Hygie other lent, It		12. Tather's Name (First, Middle, Last)	11		MESTIC	C ENGIN		Name (Fi	irst, Middle, Mai	WN_HO\ den Sumami			
<u>lan</u>	uld be dental rked o	To Be	JOHN O'DONNELL					AT.T	CE MO	PAN				
Mary	and h		19a. Informant's Name/Relationship (T	ype, Print)	19b	. Mailing Ad	ddress (Street	00.70000		oute Number, C	ity or Town,	State, Zip	Code)	
Z ď	s 1 and 3 f Health item 27 other tr		EDNA NIEBERLEIN /	DAUGHTER	20b. Place of	1310 Z	ARTZONA	AVE.	БАІЛ	TMORE,		1206		
סנפ	e ° = 5	-	20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	cemeter	ry, crematoi	ry`or other plac	. 1			. Location -			
IIIMor	permit. Pag Department Important: any injury c		* 4 □Donation 5 □ Other (Specify  21. Signature of Funeral Service Licent		MORELA	_	MORIAL me and Addre		23/0		ALTIMO		MD	-
Ö	Depril		1 6	and the second of the second o						H/ROSEDA ALTIMORI			Character Co.	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the cause on each line.		not enter the	e mode of dyir	ng, such as car	rdiac or re	spiratory arrest,			Approximate Interval Between	
	nysician		Immediate Cause (Final disease or condition	a. As	cirat	in	Hy	oxacr	ma				Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):	U1	oxaen Accia	dom	<i>t</i>				
ļ.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence	of):	on	Bucc						
نتا	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	De	ment	à								
Ď,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence	of):								
09/8	certificate be executed nding physician and use as the burial-transit	dicai	•	d	Hirt	noc	<u> </u>							-
OX O	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date	of deliver	v	
. Box	death	Iclar	in the past 12 months?	1□Live birth 2 4□Pregnant at tir			opic pregnancy ner (s <i>pecify</i> ) _	/			Mon		Day Year	
л О	at the by th	hys	9 Unknown	9□ Unknown										_
	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Dther significant conditions co	ntributing to death but	not resulting ir	n the underl	tying cause giv	ren in Part I.		23e. Did tobac 1 ☐ Yes		ibute to the 3   Proba	cause of death?	
Ö	w require been si should l	eted							-					_
Vital Records,	9 4 9	Completed							_	24a. Was an autopsy performed	1? - 8	rior to com eath?	sy findings available pletion of cause of	,
ta	ician: Th	0	25. Was case referred to medical					26. Place of	Death (C	1 Yes 2 2	No 1	☐ Yes :	2∐ No	-
5	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🔲 Inpatient	2 🗆 ER/Ou	itpatient 3	DOA Oth			5 🗌 Residence	e 6 Othe	r (Specify,		
	ding Pt h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day )		Time of njury	28c. Injur Wor			. Describe how i	njury occurre	ed		
DIVISION	or Attending after death. Director: After in by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	( - At home fa			Yes 2 □ No		Location (Stree	t and Numbe	or Rural	Route Number	
2	after after Direct	Certification;	4 ☐ Homicide determined	building, etc.	(Specify)	, 30,000,	radio y, dirios			City or Town, S			, , , , , , , , , , , , , , , , , , , ,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ertifying Phy	vsician: To the best of	my knowledge	e, death occ	curred at the tir	me, date and p	olace, and	due to the caus	e(s) and mar	ner as sta	ted.	-
	the Hin 24 the Fu	Aedical	one)	iner: On the basis of e and manner state	id.	WOI INVESTI			occurred 8					
	To To Con	Σ	29b. Signature and title of certifier	2 M	D		29c. Licens	SIU 6	Ġ		Date signed			
	11		,	ompleted cause of dea	th (Item 23a)	(Type Print					11	-		_
	10		SHOALIS A. HA	SHMI MD.	851 N	. EU	MWSI	Ente	220	of Bal	hmer	e mi	21201	
	Sta		31. Date filed (Month, Day, Year)	32/Registrar	s Signature	Lan	M 3							
	Registr	ar	SEP % 6 20	10 per la la la la la la la la la la la la la	a Also	The state of the s	Part .							

			1- State of Maryland Registrar	/ Depa		t of H	ealth a		lental Hyg	_		30415
		1	Decedent's Name (First, Middle, Last)						2. Date of Dea	th	, , ,	3. Time of Death
	Physici /Medic		Phillip Ellsworth Foos						Septembe	er <sup>Day</sup> 24	2006	1:25 A.M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location o	f Death		4c. Count	y of Death	
130			8613 Chelsea Bridge Way				ille			Balt		County
- 15 v	Funeral Director		5. Social Security Number 212-32-5006 6. Sex 1 ★ 2□ F 7. Age (In yrs. last 7. Age (In yrs. l	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) June 11	Year)	9. Birthpl Count Mary	ace (State or Foreign Try) Land
	land land		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation						10	Od. Inside City Limits
	Mary Fled	tor	Maryland Baltimore County Luthe	ervill	le							1 ☐ Yes ZXNo
	or 28	ired	10e. Street and Number		10f. Zip	Code			1	0g. Citizen of	What Coun	ry?
	ath w	rai	8613 Chelsea Bridge Way			093				United	State	S
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f show important: if Item 22 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Exerts are must be notified at anote.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Bta	ce - America ck, White, e fy: Whi	itc.
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usua	l Occupa	ation	of work	na	16b. Kind of E	Business/Ind	ustry
2	Mithin ne.	Completed	Elementary/Secondary (0-12) Cottege (1-4or 5+)		kind of wor						C 14	1 7
2	filed w Hygier other ti	ပ္ပ	12 4	Data	Proce	25511						aryland
Maryland	d be f	Be	Hilbert Ellsworth Foos						(First, Middle, M 7ille Br		me)	
7	should be to the find Mental is marked or umatic even	<sup>L</sup>		19b. Mailir	na Address				I Route Number		State Zin	Codel
	and 2 ealth a n 27 is		Mrs. Evelyn Tontrup (Former Wife									
Je,	ss 1 a	i i	20a. Method of Disposition 20b. Place	e of Dispo	sition (Nam natory or ot	e of	1			20c. Location		
Ē	Pages nent of ant: If Its ury or o			.25,06 E	orest	Hill,	Maryland					
Baltimore,	permit. Departr Importa any inf		21. Signature of Funeral Service Licensee & Gave,	A Pe	Name and	Addres	s of Facility lterna	ativ	es Funer	ral&Cre	matio	n Ctr. P.A.
	ð, i		23a. Pert J. Enter the disease, or complications that de sed the death. shock, of heart failure. List only one cause on be line.	Do not ent	er the mode	of dying	, such as o	cardiac o	r respiratory arre	est,		Approximate Interval Between
70	Physician	97.	Immediate Cause (Final disease or condition	tec					cell			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequent	nce of):	0-1							
	_xajiiiiici	_	Sequentially list conditions b Due to force a consequent	of).								
	ted nsit	Examiner	Sequentially list nanditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ice oi):								
<u>,</u>	be executed sicien and burial-transit	Exar	that initiated events c. resulting in death) Last Due to (or as a consequent	nce of):							_	
760,	0 20	cail	d ==									
	tificat ng phy as th	-										
O. Box	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pre Other (spe						ite of deliver onth [	y Day Year
Records, P.	The law requires that the ate has been signed by th bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not null iti	ng A the ur	nderlying ca	use give	n in Part I.		23e. Did tob	\/		cause of death?
S	w req beer shou	iete	Humada 15151						24a. Was ar		18/010 01410	au findings qualtable
		Completed	CeliAE DISOA	40	/				autops	ed/	prior to com death? 1 Yes 2	sy findings avaitable ptetion of cause of
Vital	sicia s certi irecto	o Be	25. Was case referre to medical examiner?  1 ☐ Yes 2 No Hospitat: 1 ☐ Inpatient 2 ☐ ER	1/0		Othe	r		(Check only on			
on of	ng Pl	Certification: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28	Bb. Time of Injury		c. Injury Work	at ?	2	ne 5/1 Reside 28d/Describe ho	nce 6 □Oth w injury occur		
Division	tal or Attendii s atter death. el Director: A ed in by the tu	fical	2 Accident investigation 3 Suicide 6 Could not be determined determined	a farm stre			′es 2□N		28f. Location (Str	eet and Numb	ar or Pural	Pouto Number
2	spital or /	erti	4 Homicide determined building, etc. (Specify)	-,,	ot, lactory,	011100			City or Town	, State)	or marar	Nouse Number,
	Hospii 4 hour Funer ely till	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred a estigation,	it the time	e, date and inion, death	place, a	and due to the ca ad at the time, da	use(s) and mate	anner as sta and due to t	ted. he cause(s)
	To the within 2 or the complet	Me	29b. Signature and title of certifier	1.1	△ 29c.	License	number		/ 29	d. Date signe	(Month, D	af, Year)
	1		1 /ww 84h	w w	02533/mD 9/25/06						06	
11	2		30. Name and address of person who completed cause of death (Item 23	Ba) (Type, f	Print)	A	15	=16	ha R	uk		
1	/		7600 OLD DAME.	TOC	USB	2	Ü	K	7/2	04		
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signatur	e A	parti	P						
2	5,5,1		SFP 2 6 2006 May A		Car . Bear							

State of Maryland / Department of Health and Mental Hygiene 2006 30416 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day homas 2006 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WAShington Med. Ctr ColeN BUrNIE If Under 1 Year If Under 24 Hrs. ial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Hours 217-62-6586 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7623 PARADISE BEAC 21122 Funeral Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2♥No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced MITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) *lechanic* marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be VERNON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Department of Health a Important: If item 27 Is any Injury or other tra PASADENA, MO-ZIZZ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 9-26-06 HANDLE 4 Donation 5 ☐ Other (Specify) 21. Signatur of Furlera Service Licensee 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23d. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) HEAVI DISEASE Arterioselerotic Examiner Due to (or as a consequence of) Physician/Medical Examiner ng physician and sas the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): resulting in death) Last use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by the a page 2 should be detached 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier Deputy 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) loves, mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 6 2006 Registrar

			For State Registrar	tate of Maryla	and / Depa <i>Cen</i>	rtment of H tificate of I	leaith and N Death	Mental Hygie Reg.		6 30417
	Observatori		Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		Robert T.	tout				Septembe	V21 200	16/0:/5/-
	Examin	er	4a. Facility Name (If not institution, give street Franklin Satual	at and number) -	to 1	4b. City, Town, or	Location of Death		4c. County of Dea	in Make
-	Francis		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	Il Under 24 Hrs.	8. Date of Birth	9. Bit	rthplace (State or Foreign
	Funeral Director		213-28-1492 13M	20F 7	5 Yrs.	Months Days	Hours Min.	09/15/19	$\frac{c}{3}$ 1 GE	ORGIA
	D >		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Loc	ation				10d. Inside City Limits
	Aaryla Febor	ō	MD BALTIMOR		OSEDALE					1 Tyes 2 No
	28a-	Director	10e. Street and Number		ODLIDIL	10f. Zip Code		10g.	Citizen of What C	ountry?
	death with the Maryland ms 23s or 28s-f ehow	ai Di	1713 SUMMIT AVEN	UE			21237		USA	
	ems ?	Funeral	Tr. Islantar States	Was Decedent Ever in	n U.S. 13. W	/as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Whi	
2-0036	within 72 hours after death with the Marylan liene. I than "natural", or Items 23a or 28a-f ehow The Majisal Examinar must be nutified at	by		1 ⊡ Yes 2 <b>⊡\</b> No If Yes, Give Year or Dates:		□Yes 21X No	Specify:			WHITE
ဂ ဂ	72 hc	Completed	15. Decedent's Education (Specify only highest grade co	on mpleted)	(Give k	ent's Usual Occupa	during most of work		. Kind of Business	s/Industry
7	within ene. then "	mpi		College (1-4or 5+)		O NOT use retired	,	T	ELECTRO	NICS
7	H Hyg	BeC	10 17. Father's Name (First, Middle, Last)	_0	TV	REPAIR		e (First, Middle, Mai		.1100
yland	nould be I Mental narked c	To B	ROBERT A. FOUT	S			THELM?	L. PI	ERRY	
Mar	2 sho and I ie ma		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing	Address (Street a	and Number or Ru	al Route Number, C	ty or Town, State,	Zip Code)
	s 1 and 2 should if Health and Men item 27 is marks other traumatic		SHIRLEY A. FOUTS 20a. Method of Disposition	/ SPOUSE	2 FE	RNSELL			TIMORE,	MD 21237
5	Peges nent of h int: If ite		1 ☑Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	cemetery, crem	atory`or other plac	(a)		·	
altimore,	permit. Peges Depertment of Important: If I eny Injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	G.	ARDENS				ALTIMORI	E, MD UNERAL HOME
ñ	permit. Depertm Importa eny Inju		16		12	11 CHES	SACO AVE	ENUE BALT	IMORE,	MD 21237
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as a complex of the compl	ons that caused the d ause on each line.	leath. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Card	iac a	rest				montes
	Examiner			Due to (or as a cons	sequence of):	interest	10.			minutes
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons						petrolog
p	cuted nd ransit	Examin	Cause (Disease or injury that initiated events							
໘ົ	cate be executed physicien and the burial-transit	i Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
8/60,		dicai	d							
ROX	death certif e attending id for use as	n/Me		If yes, outcome of pre 1∐Live birth 2 □ F		Ectopic pregnancy			23d. Date of de	
	that the death certif ed by the attending detached for use as	Physician/Me	in the past 12 months?	4☐Pregnant at time of		Other (specify)		· · ·	Month	Day Year
7.	iaw requires that the as been signed by th 2 should be detache	/ Ph	Part II. Other significant conditions contrib	uting to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did tobac	co use contribute t	to the cause of death?
Hecords,	w requires that s been signed b should be deta	d by						1 <b>[∄</b> Yes	2 □ No 3 □ P	robably 4 Unknown
<del>ပ</del> ္ပ	s beer	Completed						24a. Was an	24b. Were a	utopsy lindings available
	The la	mo:						autopsy performed 1 Yes 2 2	l? death?	completion of cause of
Vital	sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?					th (Check anly one)		
	his bi	P.	1 ☐ Yes 2 No Hosp 27. Manner of Death 2	Ital: 1 ☐ Inpatient 2	28b. Time of	3 DOA Oth	er: 4 Nursing H	ome 5 Residence		ecify)
0	ding Ph th. After th funeral	tion	1 Katural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury	28c. Injun Worl	k? Yes 2 □ No	200. Describe now	injury occurred	
DIVISION OF	r Attender death rector:	Certification:	2 Could not be	8e. Place of Injury - A building, etc. (Spe	At home, larm, stre	et, lactory, office		28f. Location (Stree City or Town, S		Rural Route Number,
5	epital or ours afte neral Dir filled in									
	호수 교 후	edicai	29a. Certifier 1 (Check only one) 1 (Machine) 1 (Machine) 2 (Machine) 1 (Mach	an: To the best of my On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tin estigation, in my o	ne, date and place. pinion, death occur	and due to the caus red at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the Hoe within 24 ho To the Fun completely	Me	29b. Signature and title of certifier			29c. License	e number	29d.	Date signed (Mon	nth, Day, Year)
)			1	no		03.	1931		9/22/0	06
	12		30. Name and I dress of person who comp	- 0	(Item 23a) (Type, F		B. 1+	we M	1 717	26
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Si	ignature				07 (10)	صا ک
	Registr		31. Date filed (Month, Day, Year) SEP 2 6 2006	Jan Liver	As Again	els)				

			1 - State of State of Registrar	Maryland / Do	epartment o Certificate d	f Health an of Death	d Mental Hyg	iene 20	06 301	+18
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  George Freter				2. Date of Dea Month Sepfelly	Day	3. Time of D	
	Examir	er	4a. Facility Name (If not institution, give street and num.  Keswick Multicare Center	•	Bal	n, or Location of C			N/A	
	Funeral Director		5. Social Security Number 198–26–4468   6. Sex 1 № M 2 □ F   7	. Age (In yrs. last birthe 100 Yr	Months Da		Hrs. 8. Date of Birth (Month, Day Feb. 25	, 1906	9. Birthplace (State or Country) Pennsylvar	
	Maryland I-f ehow	tor	10a. State 10b. County Maryland Baltimore	10c. City, Town	or Location kesville				10d. Inside City	
	h with the 23s or 28s	Funeral Director	10e. Street and Number 3800 Old Court Road		10f. Zip Cod	1208	1	0g. Citizen of Wi	nat Country?	
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow he Madical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Grey Year or Dat	ZZMio	13. Was Decedent If Yes, specify C		? (Specify Yes or No- uerto Rican, etc.)		- American Indian, White, etc. White	
21215-0	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Iteme 23a or 28a-f show event, the Madical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-12) 4	(c)	ecedent's Usual Oc Give kind of work do ife. DO NOT use re armacist	ne during most of	working	16b. Kind of Bus	Independ Pharmacy	
Maryland		To Be (	17. Father's Name (First, Middle, Last)  Benjamin Freter				Name (First, Middle, Innah Ca	Maiden Sumame, L'SON		
_	nd 2 sha lith and 27 ie m r traum		19a. Informant's Name/Relationship (Type, Print) Irving Settleman Nephew	2	01 N. Cha	rles Str		. ,	tate, Zip Code) :imore,MD21	201
Baltimore,	Page lent o nt: If ry or		20a. Method of Disposition  1 ☐ Burial 2XX Cremation 3 ☐ Removal from S  4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	Disposition (Name of crematory or other Crematory	place) 9	/22/2006	Catonsvi	ity or Town, State .lle, Maryl	.and
Ball	permit. Depurtm Importa any nju		21. Signature of Funeral Service Licenses	D)	JUJI Tal	is modu,	tz Funeral Baltimore	, Maryra	nc. 21211 nd	
	Physician /Medical		23a. Pant1. Ented the disease, or complications that car shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death)	ch line.		dying, such as car	diac or respiratory arr	est,	Approximate Interval Betwee Onset and De	en ath
8760,	cate be executed by species and the burial transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	fee usch ras a consequence of) Reference of) ras a consequence of)	asenew		left f	oot	Years	2
O. Box 6	The law requires that the death certifical the has been signed by the attending plage 2 should be detached for use as to	by Physician/Med	in the past 12 months?	ome of pregnancy h 2 Fetal death nt at time of death nn	3 ☐Ectopic pregna 5 ☐ Other (specify			23d. Date Monti		ar
ds, P	puires that n signed b ild be deta		Part II. Other significant conditions contributing to dea	th but not resulting in t	he underlying cause	given in Part I.	23e. Did tol		ute to the cause of dea	
al Records,	9	Completed					24a. Was a autops perforr	ned? de	ere autopsy findings av or to completion of cau ath? ] Yes 2  No	allable ise of
VIta	eician: Th certificete irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inc.			OII /	Death Check only on			
ion of	Hospital or Attending Physician: 14 hours alter death. Funeral Director: Afler this certific tely filled in by the funeral director.	ation; To	27. Manner   Death 1   Natural   5   Pending   2   Accident   Accident   1   Accident   2   Accident   2   Accident   1   Accident   2   Accident   2   Accident   3   Acci		Outpatient 3 DOA Cher. 4 Varsing Home 5 Residence 6 Other (Specify)  Time of Injury Mork?  M 1 Yes 2 No					
DIVISION	tal or Atters after de al Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of building	f Injury - At home, farm I, etc. <i>(Specify)</i>	, street, factory, offi	СӨ	28f. Location (St City or Town		or Rural Route Numbe	er,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner.	is of examination and/o	or investigation, in m	ly opinion, death o	lace, and due to the ca occurred at the time, d	use(s) and manrate and place, an	ner as stated. d due to the cause(s)	
	/	2	29b. Signature and title of certifier  M. Ballelle Vac An	ega to	01	3657		٦	Month, Day, Year)	
	り		30. Name and address of person who completed cause PLABELLE THERE FO	R, 700W	rpe, Print) 40 H S	TREET, R	BALTO. HO	21211		
	Sta Registr		31. Date filed (Month, Day, Year) 32. P	istrar's Signature	Sperke					

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 22, 2006 Physician 115 AM Charlotte E. Ford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Homewood Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-01-8261 1 ☐ M 2XXF Yrs. 79 Director May 27, 1927 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show other traumatic event, the Mudical Examin an must be nutified at Maryland N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Bellona Avenue 21212 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Yes 2 12 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 🏋 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 8 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery injury or other traumatic event SINE. 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Ford Dorothy Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Stocksdale Sister 212 Aigburth Road Apt 402 Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/30/2006 Lake View Memorial 4 □ Donation 5 □ Other (Specify)

21. Signatur → Fineral → vice iconsee Eldersburg, Maryland Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Naltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Approximate Inlerval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ENCEPHALOPA747. /Medical Examiner AIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physiclan/Medicai IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Peath Check only one Other: 4 Jurising Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA မှ 1 Tes 2 3 Mo 27. Mann Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred s after decreal Director: After 1 Aatural 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier ŝ 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL 20062235 STATEMBER 25 2006 ATTENDING 30. Name and address of pers o mpleted cause of death (Item 23a) (Type, Print) M W HOSPITAR BATIMOR SAMARITAN 600D

Registrar

31. Date filed (Month, Day, Year)

SEP 2 6 2006

32. Ragistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer 2006 8:02 PM September 19 Physician Kameryn Fassler /Medical 4a. Facility Name (If not institution, give street and number)
Greater Baltimore Medical Center 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2□F Director 9/19/06 Baltimore MD Unknown Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Owings Mills Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21117 9 Greenshire Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Iten eny injury or other traumatic event, the Medical Examinari ODEs. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant 0 Infant  $\cap$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shawn D. Quickley 2 Brian A. Fassler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATHO DWSON M 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 F
4 Donation 5 Other (Specify) 3 Removal from State Darvi (cemaroux C006 22 Name and Address of Facility 21. Signature of Funeral Service Licenses \$ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Pnysician 20 1 hr 35mms Cardiopulmonary failure /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Thipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P After this 28c. Injury at Work? neral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 156-Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 36680 M My Tron Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Medical Center iverman 31. Date filed (Month, Day, Year) SEP 2 6 2006 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland				Mental Hy		06	30421		
	T.M.		1. Decedent's Name (First, Middle, La	st)						eath		3. Time of Death		
	Physici /Medic		Laurence Fost	er			Month   Sept 23, 2006   4c. County of Death   4c. County of Death   Prince George's   4c. County of Death   Prince George's   Month   Days   Hours   Mn.   Oct 13, 1927   Month   Days   Hours   Mn.   Oct 13, 1927   May hew, MS   Mn.   Oct 13, 1927   Mn.   Oct 14, 192							
	Examin	er	4a. Facility Name (If not institution, giv 7005 Vismanco						ath	1	•	ooraata		
*	Funeval		5. Social Security Number 6. S		ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth	Day Year   3. Time of Death   6:00 A M    4c. County of Death   Prince George's    9. Birthplace (State or Foreign Country)    1927   May hew, MS    10d. Inside City Limits   1   Yes X No    1. Citizen of What Country?    United States   14. Race - American Indian, Black, White, etc.    Specify: White    b. Kind of Business/Industry    Teamsters Union    Iden Sumame    In    City or Town, State, Zip Code    WID 20735    c. Location - City or Town, State    Cheltenham, Maryland    Home, Inc 6633 Old    ton, MD 20735    Approximate    Interval Between    Onset and Death    Country   Month    Day Year    Country   Year			
г	. Funeral Director			<b>∑</b> M 2□ F	78	B Yrs.	Months Days	Hours Mi	0ct 15	, 1927	Coun	itry)		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits		
	Maryl. f sho	tor	MD Prin	ce George	C1:	inton								
	h the	irec	10e. Street and Number			77				10g. Citizen of	f What Coun	itry?		
	236 c	ralD	7005 Vismanco	,			207	35		Uni	ted St	cates		
36	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28e-f show its Modeal Executive in the coefficient	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1. These 2 In the Second Property 18 12 12 12 12 12 12 12 12 12 12 12 12 12	?	1	f Yes, specify Cub	an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	BI	lack, White,	etc.		
2-0	72 hours "neturel",	ted	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	lent's Usual Occup	pation during most of w	ndkina	16b. Kind of	Business/Inc	dustry		
21215-0036	be filed within 72 ho ital Hygiene. id other then "netun event, Italia is	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	d)		Tooms	tone I	Īnian		
	filed withi Hygiene. other then ent, tre M	e Co	17. Father's Name (First, Middle, Last	1		1101	essionar					лгон		
lan	should be filed withir and Mental Hygiene. marked other then matic event, the M	To Be	James L. Fo	ster				L	orene Gr	een				
Maryland	2 2 3		19a. Informant's Name/Relationship (Ruby Foster (Wi			19b. Mailir	g Address (Street	and Number or I	Rural Route Numb	er, City or Town	n, State, Zip	Code)		
	s 1 and 2 of Health item 27 l		20a. Method of Disposition		20h Pi									
nor	Pages 1		1XXBurial 2 Cremation 3					ce) _						
altimore,	1 5 4 5		*4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		Hai	-		j j	-					
ä	Depar Depar Impor any ir		Wishley	Il po	1015	3 A	lexandri:	a Ferry	Road, C1	intone,	MD 207	735 OIG		
ı,			shock, or heart failure. List only	plications that cause one cause on each I	d the death ine.	. Do not ent				arrest,		Interval Between		
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or s	· Cr	NCE	K, OM	ALL	CEAL	719		. /		
	Examiner				а сопѕеци	ierice or):								
9	P #	iner	Sequentially list conditions, if any laccing to immediate cause. Enter Underlying	Due to (or as	a cons	ence of:								
71.	icate be executed physician and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	ience of):								
68760,	e be e sician s buria	calE	· ·	ď	,	,								
W.	tificati ng phy as the	dedical												
О. Вох	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as It	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3		<i>y</i>		1		*		
ds, P	ires that signed b	by	Part II. Other significant conditions											
ecords,	w require been si should b	Completed	1000	1000	De	i.n.	Mes	rens 1	24a. Was		. Were autor	osy findings available		
$\alpha$	The lav	отр	1 1:	p g	,	7	1010	2, 140 (	реп	ormed?	death?			
Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of D						
of V	Physician: this certificatal director,	မ	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		ER/Outpatien	1 3LI DUA	4   Nursing				9		
	frei frei frei frei frei frei frei frei	tlon	27. Manner of Death  1  Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury			28d. Describe	now injury occu	Irred			
Division	al or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not b		jury - At ho tc. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and Nurr wn, State)	nber or Rura	Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Medical C	29a. Certifier (Check only one)  Certifying Plant 2 Medical Example 1	nysician: To the best miner: On the basis of and manner st	of examinat	vledge, death ion and/or in	n occurred at the time to restigation, in my control	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as st	ated. the cause(s)		
	To t withi To tl	Σ	29b. Signature and alle of certifier	121 males	Wil	()	29c. Licens D238			29d. Date sign Sept 2				
	- 41		30. Name and address of person who	completed cause of	death (Item	23a) (Type				Sept Z	J, 200	10		
	101,		Glenn R. Edgeco	U				3201, C1	inton, M	D 2073	5			
		State Registrar  31. Date filed (Month, Day, Year)  \$\int \text{SEP 2 6 2006}\$  32. Registrar's Signature												

			State of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hyg	iene <sub>ag. No.</sub> 2006	30422
			Registrar  1. Decedent's Name (First, Middle, Last)	Timcale of Dealif	2. Date of Deat		3. Time of Death
Е	Physici		Katherine Josephine Grefig		Month Septembe	er 23, 200	
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	J-F	4c. County of Dea	
			4880 Jones Drive	Fort Meade		Anne A	runde1
	Funeral		5. Social Security Number 6. Sex 1 M 2 T F 97 Yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		053-16-2422 87 Yrs.  Usual Residence of Decedent		Sept 16.	, 1919 Ne	w York
	yland		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Hilled	ctor	Florida Palm Beach Boynto	n Beach			1 Yes 2 No
	ith th	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What C	ountry?
	e 23e		38010 Frenchmans Bay	33436		United	
_	hours after death with the Maryland tural, or Items 23s or 28s-1 show al Exeminat must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.   13. Armed Forces?  1   Never Married   2   Married   1   Yes   2   2   2   No.	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
2	urs al	þ	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	hite
215-0036	72 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation  e kind of work done during most of work	ina	16b. Kind of Business	/Industry
7	han "	nple	Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)	9		
7	Hygier Hygier ther ti		12 17. Father's Name (First, Middle, Last)	Homemaker  18. Mother's Name	/First Middle A	Own Ho	me
a	should be filed within 72 hours after death with the Marylan of Mental Hyglene. marked other than "natural", or items 23s or 28s-f ehow merked other than "natural", or items round be reclifted at impete event, the Medical Examination must be reclifted at	o Be		Catheri		McCartin	
Maryland	shoul nd Me mark	2	Michael Ryan  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	ing Address (Street and Number or Rura			Zip Code)
ž	alth a 27 ie			Frenchmans Bay Bo			
Š.	of Her		20a. Method of Disposition 20b. Place of Disp		-	20c. Location - City or	
Ĕ	Pag ment ant: I ury o		1 □ Burial 2 XCremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  West Arun	del Crematory 9/27	/2006	Odenton,	Maryland
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tem 27 ie marked eny Injury or other traumetic evonce.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Donaldson Funeral H 11 Annapolis Road	lome & Ci	rematory,	P.A.
П			23a. Part1 anter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final	ive pulmonary dise	250		Onset and Death  Vears
•	/Medical		resulting in death)  a. Only on the consequence of):	.ive paimonary area	abe		years
	Examiner	ē	Sequentially list conditions, b.				
	led Isit		If any, leading to immediate cause. Enter funderlying Cause (Disease or injury				
F	al-trai	Examin	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8/60,	icate be executed physician and s the burial-transit	dicai	d				
0	₩ O 0 0	Medi					
Š	death certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 □ Live birth   2 □ Fetal death   3	□Ectopic pregnancy		23d. Date of de	,
5	the atten the atten	Physician/Me		Other (specify)		Month	Day Year
7.	that the		Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23a Did tob	acco use contribute to	the cause of death?
ras,	w requires that the death cer been signed by the attendin should be detached for use	ed by	dementia				robabły 4 ∐Unknown
ecol	law rei as bee 2 sho	Completed			24a. Was ar		utopsy findings available
r	The law ate has page 2:	E			autopsy perform	y prior to ned? death? □XNo 1 □ Yes	completion of cause of : 25☑ No
VII	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	26. Place of Death		7	A
	£ 5 m	ပ္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ont 3 DOA Other: 4 Nursing Ho	me 5 Reside	nce 6 Other (Spe	Daughters Residence
<u></u>	ding Ph. h. After thi funeral	ertification;	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe ho	w injury occurred	
JIVISION	death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		28f Location (St	reet and Number or R	ural Pauta Number
<u> </u>	al or Attending F s after death. I Director: After d in by the funera	erti	4 Homicide determined building, etc. (Specify)	noot, laboury, office	City or Town	, State)	arai i lobio i lambor,
	To the Hospital or Atten- within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier  (Crieck only Check only 2   Medical Examiner: On the basis of examination and/or if	th occurred at the time, date and place,	and due to the ca	use(s) and manner as	s stated.
	thin 24 thin 24 the F	Medi	one) and manner stated.  29b. Signature and title of certifier	29c. License number		ed. Date signed (Mont	
)	7¥ ¥ G		/ /		1		
	3		Name and address of person who completed cause of death (Item 23a) (Type	10 D5072 Externs thuy M	11	1,1	
	10	6	Jenn for Riedingermo 8601 Ve	teranstwy M	Morsi	le MD	21108
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	SEP 2 6 2006	Ma. I			

			1 - State Registrar	State of M	aryland / Depa	artment of H			ene . No 2006	30423
			Decedent's Name (First, Middle, Las	7)				2. Date of Death		3. Time of Death
	Physici /Medic		MARY M. GRA	wt				Month O9	ZZ ZOOC	0450 AM
	Examir		4a. Facility Name (If not institution, give	street and number	)	4b. City, Town, or	Location of Death		4c. County of Deat	
			8304 Sunnybrook	Court		Brandy			Prince G	
	Funeral		5. Social Security Number 6. Se	X 7. A	ge (In yrs. last birthday)  (C) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign ountry)
	Director		250-90-0209 Usual Residence of Decedent		60 Yrs.			2/22/1	946 Sou	th Carolina
	ow ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary F-f sh	to	MD Princ	e George	Brandywir	ie				1 ☐ Yes 2 📉 No
	or 28g	Director	10e. Street and Number 8304 Sunnybrook	Count		10f. Zip Code	20612		Citizen of What Co	
	s 23a	ral			5		20613		United St	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland Mantal Hygiene. marked other than "natural", or Itams 23a or 28a-f show imatic event. Ita Medical Examer must be routilled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give A Year or Dates:	No	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Afr	e, etc.
2-0	72 ho	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occupa kind of work done of	ation	16	b. Kind of Business/	
2	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired,	)	ng		
21	filed w Hygier other th	ပ္ပ	n/a		House	keeper -			lousekeepi	ng
and	be find Hall Had other	Be	17. Father's Name (First, Middle, Last)  Jack McCray					<i>(First, Middle, M</i> a. Cray Gamb		
Š	should ind Men s marka umatic	ဥ	19a. Informant's Name/Relationship (7	vne Print)	19b Mailir	na Address /Straet a			City or Town, State, 2	Zin Code)
	S S		Wanda M. Grant- R			-			*	
ē,	of Health item 27 other tra		20a. Method of Disposition		20b. Place of Dispo	THE RESERVE THE PARTY OF THE PA	The second secon		c. Location - City or	
Ë	Pages nent of I ant: If its ary or o	li	1 Burial 2 □ Cremation 3 □  1 4 □ Donation 5 □ Other (Specify		1	lvary Cen	1	G	eorgetown	, S.C.
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	1 1			s of Facility Lee	Funeral	Home,Inc	6633 01d 20735
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	d the death. Do not ent					Approximate Interval Between
N	Pnysician i		Immediate Cause (Final disease or condition	Chon	vic Rena	1 Frilas	14			Onset and Death
	/Medical		resulting in death)	a Due to (or as	a consequence of):	· raction				Creation
	Examiner		Sequentially list conditions.	. ENDON	netrial C	ARCINO	SARCON	14		16 months
	sit s	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
p.	and A-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,0	cate be executed physician and the burial-transit	alE								
687		edical		d.						
Вох	death certific e attending p id for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		·			23d. Date of deli	ivery
		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant a		]Ectopic pregnancy ] Other (s <i>pecify)</i>			Month	Day Year
P.0	that the de led by the a detached t	hys	9 Dunknown	9□Unknown						
	Se joi ed	by	Part II. Other significant conditions co	a.					co use contribute to	
0	w require	eted	DIABETES, UNION	ic mype	ztension,	Depression	<b>y</b>	1 🗆 Yes	2/2/10 3/11	obably 4 Unknown
Vital Records,	e lav has je 2	ompleted						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
a	ician: The certificate harector, page	O	05.11					performed 1 ☐ Yes 2	No 1□Yes	2□ No
₹		o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	Othe	26. Place of Death		- 0 Flort - 1/0	
ō	ding Phys h. After this funeral di	$\vdash$	27. Manner of Death	28a. Date of Inju	ury 28b. Time of	28c. Injury	at 2	28d. Describe how	e 6 Other (Specinjury occurred	city)
<u>o</u>	ttending death. stor: After the fund	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ly Year) Injury	Work M 1 □ Y	:? /es 2 □ No			
Division	or Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, str tc. (Specify)	eet, factory, office	:	28f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
ā	tal or A	Cerl	T I I I I I I I I I I I I I I I I I I I	oulding, o	ic. (Opechy)			Only of Town, C	naioj	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	sician: To the best ner: On the basis of and manner si	of my knowledge, death of examination and/or invaled.	occurred at the time restigation, in my op	e, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier			29c. License			Date signed (Month	
)			6 Llng	19 gx 114		760	00 43.	N.C. 4	7/25/06	
	10		30. Name and address of person who c	ompleted cause of	death (Item 23a) (Type,	Print)		1		Dc 20307
	4			1Axwell	WRAM	c 690	J Georgia	1 AVE N	W, Wash	DC 20307
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 6	2006 Nagast	rar's Signature	fronte)				

			1 - For Amend item#14, 1	State of MoerFH,G860,	larylar 10/5/0	nd / Depa 06 TT <sub>Cel</sub>	artmei <i>tifica</i>	nt of He te of D	ealth a Death	ind M	ental Hy	giene	200	6	30424
ź	Physici	an	Decedent's Name (First, Middle, Las  KATRINA D. HA	•							2. Date of Dea Month Septemb		, o Y	ear	3. Time of Death
12	/Medio Examir		4a. Facility Name (If not institution, give Prince George's G	street and number		al		Town, or Cheve	Location of		sep cenic	4c.	County of	Death	12:09 a <sup>M</sup>
	Funeral Director		Social Security Number 6. So			/ast birthday) Yrs.		r 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da July 20	h	0	. Birthpl	ace (State or Foreign
	with the Maryland a or 28a-f show	Director	10e. Street and Number	George's		ly, Town or Lo Laurel	10f. Z	p Code				10g. Citi	zen of Wha		Od. Inside City Limits  1 Yes 2 No  XX
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ODCE.	Completed by Funeral	11706 South Laure  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra	12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates	? ŠNo	16a. Deced	Was Dece f Yes, spi I Yes	2 No	Specify:	Puerto F			14. Race -	White, 6 Bla Wh	ck
land 21;	itd be filed with lental Hygiene ked other tha lic event, the	To Be Com	Grade 10  17. Father's Name (First, Middle, Last)  Roy Lee Dunn	College (1-40)		Rece	eptic		18. Mother Debor		(First, Middle, Hall		emeter Sumame)	СУ	
Baltimore, Mary	Pages 1 and 2 shounent of Health and Mint: If Item 27 is man		19a. Informant's Name/Relationship (7 Deborah Brown /  20a. Method of Disposition 1 XX urial 2 Cremation 3 C 4 Donation 5 Other (Specify	mother	,   (		S. sition (Na natory or	Laure	el Dri	ive #	ate	urel	., Mai	ryla y or To	nd 20708
Balti	permit. Departn Imports any inju		21. Signature of Euroral Service Licen	see /	′ M00	770 22 770 3	oonai 313 T	dsöns albot	funer t Ave	ral E	Home, P _Laure	.A.			20707
8760,	The law requires that the death certificate be executed  X  X  X  A  A  A  A  A  A  A  A  A  A	dicai Examiner	23a. Part1. Enter the disease, or dom; shock, or heart failure. List only of the shock of the sh	a. My Lu  Due to (or a  Due to (or a  Due to (or a  Due to (or a	s a consect	L CW/ (uence of): Cance, (uence of):	K (U	DVV	, such as c	eardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death
P.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	ıl death 3 □	Ectopic p Other (s	regnancy oecify)				2	23d. Date o Month		y Day Year
rds, P.	w requires that: been signed b; should be deta	Ď	Part II. Other significant conditions co	entributing to death	but not res	ulting in the ur	nderlying	cause giver	n in Part I.		1	bacco u		te to the	e cause of death?
al Reco	n: The law re ficate has be r, page 2 sho	Completed	Ascrtes Mromhourtoseala									sy med? 2 No	prio dea	r to com	sy findings available pletion of cause of
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation; To Be	25. Was case referred to médical examiner?  1  Yes 2 No  27. Manner of Death 1  Accident Pending investigation	Hospital: 1 Inpat  28a. Date of Inj (Month, D.		ER/Outpatien 28b. Time of Injury		Other 28c. Injury Work	r: 4 ☐ Nurs	sing Hom	(Check only on te 5 ☐ Reside 8d. Describe h	lence 6		Specify,	)
Divis	pital or Atte	i Certification;	3 Suicide 4 Homicide  6 Could not be determined	building, e							City or Tow	m, State)			Route Number,
	within 24 ho To the Fun completely	Medical	(Check only one)  2 Medical Examone)  29b. Signature and title of certifier	vsician: To the bes iner: On the basis and manner s	of examina	ition and/or inv	estigation	n, in my opi	nion, death	occurre	d at the time, o	date and	place, and	due to	the cause(s)
)	7		30. Name and address of person who of		death (Iter	п 23а) (Туре, I	Print)	Do	043	662		4/	20/0	Ψ	
*	Sta Registr	_	31. Date filed (Month, Day, Year)  SED 2. 6. 201	32 Regis		ature	A STAN								

			For State Registrar		State	of Maryl	land / Dep <i>Ce</i>	ertificate of	lealth and Death		giene?	2006	30425	
	Dhomini		1. Decedent's Nam	ne (First, Middle,	Last)					2. Date of De Month		Year	3. Time of Death	
	Physici: /Medic		William	Frank H	ookings					Sep. 2	22, 20	006 Year	3:07 P M	
	Examin		4a. Facility Name			umber)		4b. City, Town, o	or Location of De	eath	4c. C	County of Death	1	
			Gilchri	st Hosp	ice Cent	er		Towson				ltimore		
	Funeral		5. Social Security		5.Sex 1⊠M 2□F		yrs. last birthday	Months Days	If Under 24 H	lin. (Month, Da	v. Yeer)	Coi	nplace (State or Foreign untry)	
H	Director		216-17-3 Usual Residence			82	Yrs.			Feb. 1	.8, 19	924Eng1	and	
	land ow		10a. State	10b. County		10c	. City, Town or L	ocation		·			10d. Inside City Limits	
	Mary -f eh	tor	MD	Baltime	ore	т	uthervi	110					1 ☐ Yes 2 🔼 No	
	r 28a	rec	10e. Street and Nu	1	OLC		delict vi	10f. Zip Code			10g. Citize	en of What Co	untry?	
	h with	Funeral Director	1408 C	harmuth	Road			21093			Brita	an		
	deat	ner	11. Marital Status			cedent Ever	in U.S. 13	. Was Decedent of H		(Specify Yes or No		4. Race - Amer		
Q	after or Ite	E.		ried 2 Marrie		2 X No		1 ☐ Yes 2 No	Specify:	eno nican, etc.)		Black, White	, etc.	
0500-c	ours	d by	3 🖰 Widowed	4 Divorced	Year or	Dates:		103 243 110	Specily.	white		Specify: wh	ite	
ה	72 h "natu	Completed	(Spe	15. Decedent's cify only highest	Education grade completed	1)	16a. Dec	edent's Usual Occup e kind of work done	oation during most of v	working	16b. Kind	d of Business/l	ndustry	
7	hen hen hen	d d	Elementary/Sec	ondary (0-12)	College	(1-4or 5+)		DO NOT use retire	d)		Cons	structi		
7	iled v Hygie ther t	ပိ	17. Father's Name	(First Middle L	ast)		Buil	der	18 Mother's N	Name (First, Middle	L		011	
yıarıd	ntal	Be.		y Hooki							, margan c	ouname,		
2	should od Me mark mati	5	19a. Informant's N	<u> </u>	9		19b. Mai	ling Address (Street		1 Swoden	er City or	Town State 7	in Code)	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other then "naturel", or Itema 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at		Sonya Ro			ter	The second	Charmuth					<i>p</i> 5555)	
ā,	Hear Hear		20a. Method of Dis	sposition		20	b. Place of Disp	osition (Name of amatory or other place	Noau Da	Date ,		ation - City or 1	own, State	
2	Pages ent of ht: If i			Cremation : 5 □ Other (Spe	3 □Removal from	n State			1	- 22 00	D-14	and the second of the second	No.	
раншо	permit. Pages 1 and Depertment of Healt Important: If Item 2 eny injury or other once.		21. Signature			1	netro C	rematory 2. Name and Addre	ss_of Facility	p. 23, 06	Palt	more,	MO	
Ď	Depending the policy in po		· W	m. 1.	1/all	lod		Cremation 299 Frede	Society rick Roa	y of Mary ad Baltim	land,	Inc.	28	
			23a. Part 1. Enter	the disease, or c	complications that	caused the c	death. Do not er	nter the mode of dyir	or Society of Maryland, Inc.  derick Road Baltimore, MD 21228  dying, such as cardiac or respiratory arrest.  Approximate Interval Between					
	Physician		Immediate Cause	(Final	_a M		44	10/0	n ca	neet			Onset and Death	
	/Medical		resulting in death)				sequence of):	COTO	7				[ 7-10-11 -15	
н	Examiner		Sequentially list of	anditions	b									
Y	ם =	ner	cause. Enter Und	eriving	Due to	o (or as a con	ізециється об).							
	ecute and trans	Examiner	Cause (Disease o that initiated event resulting in death)	r injury	C		sequence of):							
0/00,	icate be executed physicien and the burial-transit	E	,		Due	o (or as a con	isequence ur).							
0	icate be executed physicien and s the burial-translt	dical		•	d									
X	ding se as		IF FEMALE:		23c. If yes. o	utcome of pre	egnancy				22	3d. Date of deli		
	atter	Physician/M	in the past 12	2 months?	1 Live	birth 2 1	Fetal death 3	☐Ectopic pregnancy	у		23	Month	Day Year	
į	the d	ysi	1 ☐ Yes 2 9 ☐ Unknow		9□ Unk									
ŗ	s that	by P		42		death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco usi	e contribute to	the cause of death?	
cords,	quire n sig uld bu		Seve	ر د	040					10	Yes 2□	No 3□Pro	bably 4 Unknown	
ဒ္ဓ	s bee	Completed	Long	restiv	e Hes	+ Fai	lure			24a. Was		24b. Were aut	opsy findings available	
ב	The It	E	(000	1857	Artes	m (	Seac	٠			psy prmed 2 2 2 No	death?	ompletion of cause of	
2	an: rtifica tor, p	0	25. Was case refe		717 10	1			26. Place of D	1 Yes		1 165	200 NO	
>	ysici is ce direc	To B	examiner? 1 ☐ Yes 2 🖁	No	Hospital: 1	Inpatient	2 ER/Outpatie	ent 3 DOA Oth				Other (Spec	in hespice	
5	fer th		27. Manper of Dea	th 5 Pending		e of Injury onth, Day Yea	28b. Time	of 28c. Injur Wor	y at	28d. Describe	how injury	occurred		
NSION N	endir sath. or: A	atle	2 Accident	investiga	ation				Yes 2 □ No					
Ë	in by t	Certification:	3 🗌 Suicide 4 🔲 Homicide	6 Could no determin	ed   286. Plac	ce of Injury - Adding, etc. (Sp	At home, farm, s pecify)	treet, factory, office		28f. Location ( City or To		Number or Rui	ral Route Number,	
ב	urs al													
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death: within 24 hours after death: 7 to the Funerial Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical E	xaminer: On the	basis of exar	knowledge, dea nination and/or i	th occurred at the tir nvestigation, in my o	me, date and pla pinion, death oc	ace, and due to the ocurred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	ithin ithin ithe	Mec	29b. Signature and	d title of certifier	and ma	nner stated.		29c. Licens	e number		29d, Date	signed (Month	Dav. Year)	
	⊢ ≱ <del>-</del> ⊠		1.3:6	10. 5	· Mr	(_	MM	D	1212	9	501	×4	2 200%	
	1		30. Name and add	ress of person w	the completed car	use of death	(Item 23a) (Type	Print)			3		1	
	1		W:11,0		nclon	1 4	63		Charle	s sh	Bal	tome	we ms	
	Sta		31. Date filed (Mo	nth, Day, Year)	32.	Mogistrar's S	ignature	C. N.				717	12	
	Registr	ar		SEP 26	2006	Al ARed	15 PM	FRE THE						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 30426 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 21, Sept. 2006 8: 05pM Mary K. Heim /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 150 Wiltshire Road Baltimore Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□M 2 F 219-52-6896 Yrs. Director 56 July 13,1950 MD Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exact art must be published at 1 □Yes 2 TNo Director MD Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 150 Wiltshire Road USA 21221 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 2 Specify:White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hy lant: If Item 27 is marked oth Be John Reimer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Heim / husband 150 Wiltshire Road Balto. MD Date UNIC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bayview Crematory of other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State = 5 MD permit. Page Department of Important: If eny injury or 2006. Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD onne Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 500 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Othknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete has a autopsy performed 1 ☐ Yes 2 ☐ NO 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 흔 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 | Pending 1 Tes 2 No ours after death.

neral Director: A
filled in by the fu investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital o within 24 hours aff To the Funeral Di LET Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number )00 60 SSS 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) 1576 Merritt Blyd. Baltimore MD Dr.Jean Toppin 32, Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 6 2006 State Registrar

DHMH 17 Rev 1/2001

			1 - State of Mar Registrar	ryland / Depa <i>Cer</i>	artment of He tificate of D		ental Hygien Rag. N	2000	30427
	Physic		1. Decedent's Name (First, Middle, Last)  Nothic Martin Haccell				2. Date of Death Month D		3. Time of Death
	/Medi Examir		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or L			c. County of Death	3.17
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		If Under 24 Hrs.	B. Date of Birth	Baltimor-	lace (State or Foreign
	Director		578 - 54 - 3274 1□ M 2QF Usuel Residence of Decedent	D Yrs.	Months Days	Hours Min.	(Month, Day, Year	Count	5. C.
	ryland how			10c. City, Town or Lo	cation			1	Od. Inside City Limits
	the Ma	recto	M d N/A	Baltimor	10f. Zip Code		10g. C	itizen of What Coun	1 Nes 2 No
	th with 23a or	ai Di	3722 Cadar Drive		21207			USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland It of Health and Mental Hygiene. If Item 27 ie marked other then "natural", or Iteme 23a or 28e-f ehow or other traumatic event, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes, Give	1	Vas Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2 ☑ No	panic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:	etc.
5-0036	2 hours natural	ted by	3 Widowed 4 Divorced Year or Dates:	16a. Decec	lent's Usual Occupati	on	16b.	ار Kind of Business/Ind	dustry
2121	within 7 ene. then "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life. L	kind of work done du OO NOT use retired)		Bas	Himore C	•
nd 2	e filed al Hygie other vent, tr	Be Co	17. Father's Name (First, Middle, Last)	30110	al Admin		First, Middle, Maide	bile School	1 System
Maryland	2 should be filed withir and Mental Hygiene. ie markad other then aumatic event, the Me	P.	Booker T Martino  19a. Informant's Name/Relationship (Type, Print)	19h Mailir	g Address (Street an		noin pson	or Tour State Zin	Cadal
	and 2 sealth and 2 sealth and 27 ion		Nicola Harrall Daugho	372	2 Cadar	Delve 3	Baltimore		11207
nore	ages 1 nt of He t: if iten		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo- cemetery, crem	sition (Name of natory or other place)	Da	te 20c. I	Location - City or To	
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: if item 27 le any injury or other trat once.		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Ucensee	6 22 N Mo	Name and Address	of Facility Cha	+man - 14	altimore arris fu	Md veral Home
	20119	_	23a. Pg.1. Enter the disease, or complications that caused the	De death Do not ent	40 he ste	Syowe 1	AJ BALY	imore W	d 21215 Approximate
	Physician		oflock, or he fifailure. List only one cause on each line lone ediate Cau. (Final disease or contion	es al		ON S	respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	consequence of):	12/2				
	7 -	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	consequence of):	16/28	117	,		
•	icate be executed physicien and s the burial-transit	Examin	Cause (Disease or injury that initiated events c.	consequence of):					
8760,	ate be e nysicier he buri	dicai E	d						
9	death certific e attending pl ed for use as t	/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date of delive	rv I
.O. Box	the death y the atter iched for i	Physician/Med	in the past 12 months?  1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)				Day Year
<u>α</u>	wrequires thet the death certifi been signed by the attending should be detached for use as	d by Pt	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given	in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
Division of Vital Records,	The law req ete has beer page 2 shou	Completed by	Denendo		-		24a. Was an autopsy performed?	24b. Were autop prior to con death?	osy findings available apletion of cause of
ital	lan: Th	Be Co	25. Was case referred to medical		2	26. Place of Death	1□ Yes 2 N		2 No
of V	Physic this ce	ဥ	examiner?  1  Yes 2 No 1 Inpatient  27. Manner of Death 28a. Date of Injury			Nursing Home	e 5 ☐ Residence		)
ion	Attending in death. actor: After by the funer	ation	1 ☐Netural 5 ☐ Pending (Month, Day 1 2 ☐ Accident investigation	rear) Injury	28c. Injury a Work? M 1 \(\sum Ye	s 2 No	d. Describe now inju	ary occurred	
DIvis	i or Atte after de Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	28	If. Location (Street a City or Town, Star		Route Number,
	To the Hospital or Attending Physician: The lave; within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of e 2 Madical Examinar: On the basis of e and manner state	xamination and/or inv	occurred at the time, restigation, in my opir	, date and place, an nion, death occurred	d due to the cause(s I at the time, date ar	s) and manner as st id place, and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1	29c. License r	number	29d. D.	ate signed (Month,	Day, Year)
,	A A		30. Name and address of person who completed cause of dea	th (Item 23a) (Type	Print)	117	\	11261	20
	1		Les) 610 000H	12000	8 1), le	(000)	1107/	Taylo	Jac16 m
	Sta Regista		31. Date filed (Month, Day, Year) SEP 2 6 2006	s Signature	80 L.				

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Joan В. Harper ptember 21 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Luare KOSEA ale imore ranklin If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 1 35 7. Age (In yrs. last birthday)
71 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 212-32-9348 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits • how r than "natural", or items 23a or 28a-f ehov Tre Medical Examinar must be notified at 1 Yes 2 No Director Baltimore White MArsh MD the 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? With 21162 5943 Loreley Beach Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: SpecifyWhite Completed by Baltimore, Maryland 21215-003 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery Wards Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper 12th of Health and Mental Hygie item 27 ie marked other other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Alice Piercy Carlos Jackman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5943 Loreley Beach Road Balto.MD 21162 James Harper /husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages Department of Important: If it eny injury or o 6 Holly Hill Cemetery 9/25/06 Baltimore MD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a con equence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be defached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificefe hes t lirector, page 2 s autopsy performed2 1 Yes 28 No 1 Yes 2 🗆 No or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No fhis within 24 hours after death.

No the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Medical Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date/signed (Month, Day, Year) V Cu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 van &. Phil sm5. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar 06 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARGARET ANN HAYE' 4a. Facility Name (If not institution, give street and number) EDIEMPER 23 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner MARIEUNEK HEALTH AND REHAB ANNE ARUNDEL GLENA Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕶 F Months 234-32-1392 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 5-4 or Items 23a Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: WhITE 3 ₩idowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RAIN ODERATOR 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ATLERINE A. ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as Important: If item 27 Is eny injury or other treuonce. VASADENA MD. Z1122 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State TOMY GITTS REQUSTRY 4 ☐ Donation 5 ☐ Other (Specify) era Service License Signatu 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena MD 21122 nt . Enter the diseas . 2r com shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Yes should be detached the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy 2 No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Man of Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Predical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title ertifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) person who completed cause of death Month, Day, 32/Registrar's Signature State SEP 2 6 2006 Registrar

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Year September 23, 2006 0200 hrs **Medical Examiner** Corey Harrison 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Baltimore** n/a John Hopkins Bayview Hospital If Under 1 Year If Under 24Hrs 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or **Funeral** Days Foreign Hours Director Country) MD 218-92-3025 27 05/13/1979 1 X M 2 Usual Residence of Deceden 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 1 X Yes 2 No 28a-f show n/a MD Baltimore City Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho art. If item 27 is marked other than "natural", or items 23a or 28a-f sho ant. Transmatic event, the Metital Examiner must be notified at once. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 4532 Parkside Drive 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black. 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No Give Year 1 Yes 2 X No specify: Specify: Black 3 Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12th n/a unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Harrison Ina Jackson Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Ina Barnes / Mother 4532 Parkside Drive; Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Important: injury or oth King Memorial Park 09/25/2006 Randallstown, MD Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home, P,A. 638 N. Gilmor Street; Baltimore, MD disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö þ 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 28b. Time of Injury 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Sep 23, 2006 Subject was shot 0121 hrs Natural Pending Yes 2 🗸 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 2000 block Robb Street, Baltimore, MD (Specify) Local Street To the Funeral 4 / Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 🕡 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E September 23, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 22, 2006 Calvin C. Hoffmaster 4:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **1√2** M 2 □ F 218-18-2558 Yrs. Director May 20, 1925 \_Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ir then "natural", or items 23a or 28a-f ehor the Modical Examiner must be notified at 1 Yes XXNo Directo Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10 Haymarket Court 21236 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter neat of Heatilth and Mental Hygiene. ant if Item 27 is marked other then "natural; or Ite ury or other traumatic event, the Modical Examinatury or other traumatic event, the Modical Examinatury. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ WWII 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamster Hanover Uniform 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Franklin Hoffmaster Elsie E. Wiles ဥ 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin C. Hoffmaster, Jr 400 Ensor Court Joppa, Maryland 21085 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 9/25/2006 Timonium, Maryland permit. Page Department Important: If eny injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licenses 22. Name and Address of Facility Purgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Day 1 **Physician** Borrel 06 Shuchm /Medical Due to (or as a consequence of): **Examiner** Bladdo cancer monday Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physicien for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performer certificete 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Atother (Specify) Nospice မှ 1 ☐ Yes 2 📆 No 1 Inpatient 2 ER/Outpatient 3□ DOA his hours after death. merał Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 6 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 028303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clover St Balkune and ANON Cuarty ne 6601 N. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 6 2006 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of I	Marylan				ealth a	and M		Reg. No.		6	30432
Physic	cian	1. Decedent's Name (First, Middle, Las Elizabeth Marie Jo	•							2. Date of De Month Septem		23 2°	ar 006	3. Time of Death 11:15 AM M
/Med Exam		4a. Facility Name (If not institution, give		er)	<del></del> ,	4b. City,		Location o		·	4c.	County of D	eath	
Funera Directo		5. Social Security Number 6. Se 395-22-9466	х Эм <b>2X</b> F	Age (In yrs. 79	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 07/11/	th 1927	9. <b>W</b> I	Counti	ace (State or Foreign y)
pu s		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y. Town or Lo	cation							10	d. Inside City Limits
Maryla 1 aho	jo	MD Montgome	ry		ver Sp									VE Yes 2 No
r 28a	rec	10e. Street and Number				10f. Zip	Code				10g. Cití	zen of What	Count	ry?
th with	al D	708 Downs Drive				209	904-				USA			
DESIGNOTE, IMBRYISHIG Z I Z I 3-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mouth be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	No No		Was Dece If Yes, spe 1  Yes	44	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	1	14. Race - A Black, W Specify: W1	/hite, e	tc.
within 72 ha	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		or 5+) 2	16a. Dece (Give life. House	kind of wo DO NOT u	rk done d	furing most	t of worki	ing		nd of Busine Home	ess/Indu	ustry
Maryiand ZIZI3-UU30 nd 2 should be filed within 72 hours af th and Mental Hygiene. ZI's marked other than "natural", or traumatic event, the Medical Exami	To Be Co	17. Father's Name (First, Middle, Last) Norman H. Dabarein	ner					18. Mothe		(First, Middle,	, Maiden	Sumame)		
s t and 2 show the strength and them 27 is mother traum		19a. Informant's Name/Relationship (7 Robert F. Jordan/H				-				Spring				Code)
Saltimore, permit. Pages 1 a Department of Her important: if item any Injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		ite C	Place of Dispo cemetery, crei esapeal	natory or o	other plac			Sep 26 2006		cation - City		n, State aryland
Departr Departr Importa		21. Signature of Funeral Service Licen	cuami	m 0038		Name ar app F 33 Gi				tion Ser			l 20	910-
Physiciar /Medica		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each	sed the death hine.  thelio	ma	er the mod	de of dying	g, such as	cardiac c	or respiratory a	rrest,			Approximate nterval Between Onset and Death 3 years
Examine	Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury		as a consec	usnce of)								11	
cate be executed physician and the burial-transit		that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):									
The Coll us, T.C. DUX or The law requires that the death certific the has been signed by the attending p page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	ı 2 ∏ Feta tat time of d	Ideath 3	Ectopic p Other (sp					2	23d. Date of Month		/ Day Year
quires that n signed b	b	Part II. Other significant conditions of	intributing to deat	h but not res	ulting in the u	nderlying (	ause give	en in Part I.		23e. Did t		_	e to the	cause of death?
	Completed									24a. Was autor perfo 1 \(\begin{align*} \text{Yes}			to com	sy findings available pletion of cause of
Oi VIIGIT Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200		(Check only o	ne)			
this ald	tlon: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of I		28b. Time of Injury		28c. Injury Work	at		ne 5 Resident		Other (S y occurred	Specify)	
o the Hospital or Attending within 24 hours after death. to the Funeral Director: After ompletely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	289. Place of	Injury - At he etc. (Specif	ome, farm, str y)					28f. Location (. City or Tox	Street and wn, State,	d Number or	Rural	Route Number,
ne Hospital or n 24 hours afte ne Funeral Dir	edical	29a. Certifier (Check only one)  Certifying Phylogen 2 Medical Exemption 1975	vsicien: To the be iner: On the basi and manner	s of examina	wledge, deat tion and/or in	occurred vestigation	at the time, in my of	e, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner place, and	as star	ted. he cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	. 507	25-		29	D43	number 8083				e signed (Me -25-20		ey, Year)
10		30. Name and address of person who decorge A. Sotos					r. Ro	ckvil	lle N	4D 2085	0			
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 2 6 200	Reg.	istrar's Sign	lare .	Mass.								

State of Maryland / Department of Health and Mental Hygiens, For State Registrar 30433 006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 21 2006 7:00 p M September JIMMIE KIMBLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD CO APT T3 BELCAMP 1306 LIRIOPE STREET If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **XX**M 2□ F Yrs. 60 Director SEPT 1946 MARYLAND 213-44-9758 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f ehow r than "naturel", or Iteme 23a or 28a-f ehor the Medical Examinativ ust be nutified at 1 ☐ Yes 2 ☑ No MARYLAND HARFORD CO Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT T3 1306 LIRIOPE STREET 21017 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 72 hours after Wever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ģ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be fited within 7. In and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12yrs SUBSTANCE ABUSE COUNSELOR 2 yrs PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE KIMBLE JIMMIE KIMBLE SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 si ment of Health an ent: If Item 27 is r 184 Cameron Sta. Blvd, Alexandria, VA 22304 Shirley A. Davis/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) HARFORD MEMORIAL GAR. 09-26-06 ABERDEEN, MARYLAND 21. Signature of Funeral Service Acc 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOLE-HARFORD, P 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 WM C 23a. Part1. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My **Physician** ocare disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-fransit that initiated events attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2000 certificate 1 ☐ Yes 1 Yes Physiclen: director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death, investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury <sup>2</sup> At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital o within 24 hours af To the Funerel D 1 retifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 203% 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Davis Hahn 5601 Loch Raven Blvd., Baltimore, Maryland 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature A CONTRACT State Registrar SEP 2 6 2006

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

2006 30434

1- For State Certificate of Death Rea No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Year September 17, 2006 0935 hrs **Medical Examiner** Kristopher W. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2119 Southorn Road **Baltimore County** Essex 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. **S**ex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Director 21 220-17-6777 Oct.7,1984 Country) MD 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Yes 2 X No MD Baltimore Middle River 28a-f show death with the Maryland Director s 23a or 28a-f e notified at o 10f Zip Code 10e. Street and Number 10g. Citizen of What Country 2167 Firethorne Road 21220 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married Married 2 X No Yes 1 Yes 2 X No specify: Specify White Divorced Give Yea Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Bob's Home Elementary/Secondary (0-12) College (1-4 or 5+) 27 is marked other than ' imatic event, the Medical Baltimore, MD 21215-0036 permit Pages | and 2 should be filed within 7. Department of Health and Mental Hygiene Construction Worker 12th Inprovement 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Ricky King Maxine Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Important: Witem 27 is injury or other traumort Ricky King /father <u>8250 Northview Road Baltimore MD 21222</u> 20a. Method of Disposition 20b Place of Disposition (Name of cemetery 20c. Location - City or Town, State Holy Rosary 1 X Burial 2 Cremation 3 Removal from State 9/21/06 Baltimore MD Donation 5 Other Specify. 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Narcotic (heroin) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED AMENDED item#23a,27,28a-f,perME,g859,9/28/06 TT Box 68760, IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? ✓ Yes 2 death? 2 No 1 🗸 Yes 25 Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital 1 Other<sub>4</sub> DOA Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 V Other. Scene After this 1 🗸 Yes 2 ို 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d Describe how injury occurred Certification: Natural Funeral Director: Fnd 9/17/2006 Fnd 9:25 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide Essex, MD 2119 Southorn Road determined House 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 18, 2006 30 Name and address of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 egistrar's Signature 31 Date filed (Month, Day, Year) State Registrar SEP 9

ORIGINAL

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Directo

Completed by Funeral

Be

2

**Funeral** 

Director

item 27 is marked other then "netural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be neutified at

ntal Hygiene.

Health and Menta

nt of Health a

permit. Page Department of Important: If eny Injury or once.

ö

Maryland

the

death with

be filed within 72 hours after

Baltimore, Maryland 21215-0036

Physician/Medical Examiner burial-transit and attending physicien for use as the buria cate has been signed by page 2 should be detact ξ Completed certificate has To the Hospital or Attending Physicien: within 24 hours efter death.
To the Funeral Director: After this certifica completely filled in by the funeral director; Medical Certification; To

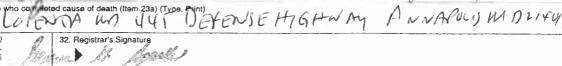
Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of o	al death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Dther significant conditions or		sulting in the underlying	g cause given in Part I.		use contribute to the cause of death?
Amputation R	iv Qun	d of	eitem	24a. Was an autopsy performed?	
25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 1 Inpatient 2	ER/Outpatient 3	Other	Death (Check only one)	6 □Other (Specify)
27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1  Yes 2 No	28d. Describe how inj	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Phyone) 1 Medical Example 2 Medical Example 2	rsician: To the best of my known iner: On the basis of examinating and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death o	ace, and due to the cause( ccurred at the time, date at	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifie	I Freit	y un	29c. License number	438 8	ate signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) SEP 2 6 2006



			For State	State of Ma	aryland / Dep		of Health			ene 1. No. 20	በ ፍ	301.36
			Registrar  1. Decedent's Name (First, Middle, Las	st)		Timouto	Or Boat		2. Date of Death		00	3. Time of Death
	Physici /Medic	al		, Koval	evski			S	Month eptembe			00301M
	Examin		4a. Facility Name (If not institution, give Northwest Hos	ostreet and number)			own, or Location dalls to		•	4c. County Ba		ore
	Funeral Director		5. Social Security Number 6. S 212–20–3363	□M 2□F	e (In yrs. last birthday Yrs.	If Under 1 Months	Year If Und Days Hours	s Min.	B. Date of Birth (Month, Day, )			lace (State or Foreign try)
	70		Usual Residence of Decedent		81	1		Dece	ember 1/	,1924	Peni	nsylvania
	arylar show	۲	10a. State 10b. County		10c. City, Town or L	ocation					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	Maryland Baltin  10e, Street and Number	iore	Randal1st	10f. Zip C	Pada		100	. Citizen of W	that Cour	X
	with 3a or		5019 Old Court 1	Pond			21133					
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Decede	nt of Hispanic (	Origin? (Speci	fv Yes or No-	14. Race	- Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; if Item 27 is marked other than "natural", or Items 23e or 28e-f show says figury or other traumatic event, the Madical Examinar must be inclified at ances.	þ	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 ☐ N If Yes, Give Year or Dates:	10	1 ☐ Yes X	y Cuban, Mexic		can, etc.)	Specify	k, White, d	
2-0	72 ho	Completed	15. Decedent's Ec (Specify only highest gra		16a. Dec	edent's Usual	Occupation done during m	ost of working	16	ib. Kind of Bu	siness/Ind	dustry
121	han "	mple	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use	retired)	ost or working		ary1an	d Sta	ite
2	filed v Hygie ther t		17. Father's Name (First, Middle, Last)	4	Deput	y Dire		ther's Name (	First, Middle, Ma	overnme		
Maryland	id be ental ked o	To Be	Matthew Kovaley						aczkows		-,	
ary	and M a mar		19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ing Address (			Route Number, (		State, Zip	Code)
	and 2 ealth n 27 i		Patricia A. Kovey	ski (Sp	ouse) 5019	-7.		oad, Ra	ndal1st	own, Ma	ary1a	and 21133
Baltimore,	Pages 1 lent of Ho nt; if Iter ry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specifi		20b. Place of Disp cemetery, cre Holy Fami	matory or oth	er place)	Dat n 09/25				wn, State 21133
ä	permit. Departm Importa any Inju		21. Signature of Funeral Service Licen	see	2	2. Name and	Address of Fac	lity Lori	ng Byer	s Fune	ral I	irectors
<u> </u>	8 2 E 8		Joseph K	lene s	200333 8	728 Li	berty R	kd., Ra	ndal1st	own, Ma	ary1a	and 21133
	Physician		23a. Payl. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.							Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	oue to (or as	consequence of	poxic	, legs	piratur	y faith	we		day
	Examiner		Sequentially list conditions,	b. End sta		hemse	ma					
	8 H/ 5	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						ĺ	
_	ficate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as	a consequence of):							
8760,	siciar b burit	SalE	(	d	0.00							
9	tificate ng phy as the	edic										
Вох	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic preg	nancy				of delive	•
	wrequires that the death certif been signed by the attending should be detached for use as	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown		Other (spec				Mon	ith	Day Year
P.O.	The law requires that the site has been signed by thoage 2 should be detached.	H.	Part II, Other significant conditions of	ontributing to death be	ut not resulting in the	underlying cau	use given in Par	rt I.	23e. Did toba	cco use contri	bute to th	e cause of death?
Division of Vital Records,	n sign	d b	Diabeter nel	- 4	mplin				1 ☑ Yes	2 🗆 No	3 ☐ Proba	ably 4 □Unknown
CO	s bee	plete							24a. Was an	24b. W	/ere autor	osy findings available
R		mo:							autopsy performe	d? d	eath?	npletion of cause of
/ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Pla	ce of Death	Check only one	) <u>/</u>		
of \	g sig	္ရ	1 ☐ Yes 2 🎢 No	Hospital: 1 Inpatie					5 Residen			)
uc	ding F	tlon:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time (	of 280	c. Injury at Work? 1 ☐ Yes 2		d. Describe how	injury occurre	ed .	
/isi	Atten r deat octor: yy the	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inje	ury - At home, farm, si				f. Location (Stre	et and Numbe	r or Rura	Route Number,
ă	s effe	Certification:	4  Homicide	building, etc	: (Specify)				City or Town,	State)		
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral	edlcal (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of the basis of and manner sta	examination and/or it	th occurred at nvestigation, in	the time, date n my opinion, d	and place, and eath occurred	d due to the cau at the time, date	se(s) and mar and place, a	ner as stand	ated. the cause(s)
	To the l within 2. To the f complete	Me	29b. Signature and title of certifier				License numbe		290	. Date signed	(Month, L	Day, Year)
)			> DKogglin	mo		1	0328	44	Se	ptembe	- 21	2006
	8		30. Name and address of person who DRoggen 5400 0	11 Count Po	eath (Item 23a) (Type ad Ran	Print) dallston	in mo	2113	Se 3 ste	. 108		
	Sta	te	31. Date filed (Month, Day, Year)	32. Fegistra	ar's Signature	partis						
	Registr	ar	SEP 2 6 21	JUD JUB SECTION	Sul Ass 19							

			1 - State Registrar	State of Ma	Cei	rtificate of L		_	Reg. No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  VERONICA M. KLO	OHR				2. Date of De Month SEPT •	Day	Year 2006	3. Time of Death 9:45a
#5	Examir		4a. Facility Name (If not institution, give s 2008 VALLEY MIL			4b. City, Town, or FREELA	Location of Death		4c. County BALT	of Death	
	Funeral Director	===	013-12-2743	7. Age M 2 <b>1</b> F	(In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Month, Da 01/29	y, Ygar) 1918	9. Birthp Coun MARY	ace (State or Foreign try) LAND
	nyland show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					10	Od. fnside City Limits
	Ba-f s	cto	MD BALTIMO	RE	FREELA						1 ☐ Yes 2 X No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
	e 23g	Fal	2008 VALLEY MI	LL RD  2. Was Decedent B	Type in 11 C 12 1	21053	annia Origina / Co	norty Voc or No	USA	e - Americ	an Indian
21215-0036	permit. Peges 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show any injury or other traumatic event. If a Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 (2) No	Specify:	Rican, etc.)	Bla	ck, White,	etc.
2-0	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa	furing most of work	king	16b. Kind of B		
7	vithin ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired			DEPART		
	iled v dygie ther t		12 17. Father's Name (First, Middle, Last)		CLER	in	18. Mother's Nam		MOTOR		CLES
Maryland	hould be to Mental Huarked of	To Be	EDWARD F . KOWA		10h Mailie	ng Address (Street a	MARTHA	F. PO	TOCKI		Codel
Ma	d 2 s Ith an 17 is r traur		WINNIE KRANTZ (D			VALLEY			-		
	Heal Heal tem (		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location		
9	Peges ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	GREEN MC	natory or other plac OUNT CRE		09/22/	06 BAI	TO.	CITY, MD.
Baltimore,	permit. I Departm Importer any inju		21. Signature of Funeral Service License	well	, E	Name and Address W. 6924 YO	JENKIN	S & SO	NS CO	1111	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a	the death. Do not ente.  a consequence of):	er the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
68760, F	tilicate be executed ig physicien end as the burial-transit	edical Examiner	Sequentially list conditions, tany leasing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	19-5077	a consequence of):						
.O. Box 6	The law requires that the death certit tie has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	ic. If yes, outcome of 1 Live birth 14 Pregnant at 9 Unknown	2 Fetel death 3	Ectopic pregnancy Other (specify)				ite of delive	ry Day Year
<u>α</u>	res that igned by be deta		Part II. Other significant conditions con-	inbuting to death bu	it not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?
rds	quires n sign	ed by	Perphere nevop	.45				1 🗆 1	res 2 10	3 🗌 Prob	abfy 4 □Unknown
I Records,		Completed	Anemic					24a. Was autop perfo 1  Yes	rmed?	Were autor prior to con death? 1 \( \sum \text{Yes}	osy findings available npfetion of cause of 2 \square
Vital	Physician: Th r this certiticate ral director, pag	Be	25. Was case referred to medical examiner?			Ī o.	26. Place of Deal	th  Check only o	ne/		
of o	Physic this o	5	ILI THIS 25-NO	spital:			4 🗀 Nursing no	ome 54 Resid		- ' '	)
n C	5 E	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of fnjur (Month, Day	y Year) 28b. Time o Injury	Work	c?	28d. Describe f	now injury occur	red	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Ptace of Injubulding, etc	iry - At home, farm, str (Specify)		Yes 2 □No	28f. Location (S City or Tov	Street and Numb vn, State)	ber or Rura.	l Route Number,
	ne Hospita 124 hours ne Funere detely tille	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of er: On the basis of and manner sta	of my knowledge, deatl examination and/or in ted.	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the tred at the time,	cause(s) and made and place,	anner as st and due to	ated. the cause(s)
	withir. To th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month, I	Day, Year)
)			30. Name and address of person who	1	eath (ftem 23a) (Type.	D3/	295		9/>	1/06	
	0		WENDY KLOESZ M				TOWSON	,MD. 2	1204.		

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 6 2006

bade

32. Segistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 25, 2006 Physician J0SEPH **THOMAS** KUNZ 7:00A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 206 Blenheim Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day) Hours Min. August 21, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1,∏M 2□ F 97 Yrs Director 213-07-9469 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiane. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 206 Blenheim Road 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XX No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Metalergist Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 ie marked o John Joseph Kunz Elizabeth Bode 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne T Prem Attorney 110 West Road Suite 435 Towson, Maryland 21204 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ New Cathedral Cemetery 9/28/06 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21. Signature of Funeral Serv 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, o complication shock, or heart failure. List only one complication Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien end s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 TEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an 1 ☐ Yes 2 After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) re D20649 2006 200

State Registrar

31. Date filed (Month, Day, Year) SEP 2 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John W Bowie MD 6701 North Charles Street Suite 4902 Towson, Maryland 21204 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** lichae 2006 20 /Medical 4c. County of Death 4b. Gity, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAGIMOVE Veterans Admin. Medical Center ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours in M 2□ F 219-56-14-13 Washington, DC 23, Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County \*ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: if item 27 ie marked other then "naturel", or items 23s or 28s-1 ehov any injury or other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Prince George Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14931 Belle Ami Drive 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1970-72 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bfack, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1₺ Yes 2□ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John C. Liberty Grace Peluzzo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Duncan /sister 14931 BelleAmi Drive, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept 26, 06 Clinton, Maryland Resurrection Cem. 22 Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 313 Talbott Ave. Laurel, Maryland 20707-4389 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Metastatic **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 Yes 2 D No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificete has all director, pege 2 a autopsy performed? 1 Yes 2 No 25. Was case referred to medicaf examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 | Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of conflict 29c. License number 29d. Date signed (Month, Day, Year) 2X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch Raven Bud harles M. Harrison ME 31. Date fifed (Month, Day, Year) SEP 2 5 2 32. Registrar's Signature State Registrar 2016

	ian cal	1 - State Amend item#8, per Registrar  1. Decedent's Name (First, Middle, Last) Baby Benjamin Will	iam Lee		4L C'- T		2. Date of De. Month	aa	Year 200 ounty of Death	
Examir	ner	4a. Facility Name (If not institution, give :		, _	-	r Location of Deatl	٦	_	a Hin	
_		Greater Baltimor  5. Social Security Number  6. Sex		nter  last birthday)	If Under 1 Year		8. Date of Bin			
Funeral Director			[M 2□F 0	Yrs.	Months Days 0 23	Hours Min.	8. Date of Bin Month Da August	<b>D</b> <sup>Year)</sup> 20		nplace (State or Fountry) Yland
works and willing at	tor	10a. State 10b. County L'Aryland Baltimore		y. Town or Lo eeland	cation			-		10d. Inside City Li
3a or 28	I Directo	10e. Street and Number 719 Jaclyn Circle			10f. Zip Code 21053				of What Co	•
tal Hygiene. d other then "natural", or Items 23a or 28a-1 show event, the Modical Exerting must be notified at	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			dispanic Origin? (S an, Mexican, Puerl Specify:		- 14.	Race - Amer Black, White	ncan Indian,
"natura	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	ent's Usual Occup kind of work done OO NOT use retire	during most of wor	rking	16b. Kind	of Business/I	ndustry
ther.	шо	Elementary/Secondary (0-12)	College (1-4or 5+) N/A	None				N/A		
ed other	9	17. Father's Name (First, Middle, Last) Kirk Theodore Lee				_	ne (First, Middle,		mame)	
nd Mental marked c	7	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailin	a Address (Street	and Number or Ru	ei Zhang Iral Route Numbe		own, State, Z	ip Code)
Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e <u>once.</u>		Mr. Kirk T. Lee (F				rcle, Fre		-		
nent of Healint: If itam ?		20a. Method of Disposition  1 Burial 2 Cremation 3 R	20b. P	-	sition (Name of natory or other pla		Date	20c. Locat	ion - City or	
Medical Medical Medical to nee as the prival-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list rondrions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of): uence of): Fallw	sepsio Epsio e	(42)				5 days
as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3□	Ectopic pregnanc	у		23d	I. Date of deli Month	very Day Year
y the attendir ached for use		Part II. Other significant conditions con	itributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t			the cause of death
gned by the be detached	۾							1	24b. Were au	topsy findings avail
0 0	۾						24a. Was			
as been signed by the 2 should be detached	Completed by						autop perfo 1 ☐ Yes	osy ormed? 2 No	prior to death?	2 No
as been signed by the 2 should be detached	Be Completed by	25. Was case referred to medical examiner?	Hospital:	500	- Ot	nor	autop perfo 1 ☐ Yes ath (Check only o	osy ormed? 2 No one)	prior to death? 1 ☐ Yes	2□ No
as been signed by the 2 should be detached	To Be Completed by	examiner?	28a. Date of Injury	ER/Outpatien	28c. Inju	ner: 4 Nursing H	autop perfo 1 ☐ Yes	osy ormed? 200,No one) dence 6	prior to death? 1 Yes  Other (Spec	2□ No
fter death. Director: Afler this certificate has been signed by the in by the funeral director, page 2 should be detached	To Be Completed by	examiner? 1 Yes 2 No	1 A Inpatient 2	28b. Time of Injury	28c. Inju Wo M 1	ner: 4 Nursing H	auto perfo 1 Yes ath (Check only of dome 5 Resident 28d. Describe	osy primed? 2 VaNo one) dence 6 C how injury o	prior to death? 1 Yes  Other (Spec	
fter death. Director: Afler this certificate has been signed by the in by the funeral director, page 2 should be detached	Certification; To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physical Processing Pro	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1 ==	ner: 4 Nursing F ry at rk?   Yes 2 No	auto performent of the performent of the performent of the performent of the performance	one) dence 6 chow injury o  Street and Awn, State)  cause(s) an	prior to c death? 1 Yes  Other (Spec courred	2 □ No  sify)  ral Route Number,  stated.
death. stor: Afler this certificate has been signed by the rthe funeral director, page 2 should be detached	To Be Completed by	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phy.	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specification).	28b. Time of Injury	28c. Inju Wo M 1 ==	ner: 4 Nursing F ry at rk? Yes 2 No me, date and place ppinion, death occu	autoperiod 1 Yes  ath (Check only of the control of	one)  dence 6 how injury o  Street and N  man, State)  cause(s) an date and pla	prior to c death? 1 Yes  Other (Spec courred	2□ No  ral Route Number,  stated. to the cause(s)

DHMH 17 Rev 1/2001

LEE, BOY B SHENG

# Please Type or Print in Black Indelible Ink

Allen Lewis	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Personal Property State S
Physician/	Registrar  1. Decedent's Name (First, Middle, Last)  Reg. No. 2  1. Decedent's Name (First, Middle, Last)  2. Date of Death
Medical Examiner	Month Day Year September 16, 2006 0809 hrs
and the same of	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	001 E. Mt. Veronon PI. Baltimore
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Months Days Hours Min Foreign
	Usual Residence of Decedent
any	10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits
ž .	Md N/A Baltimore 1 TYes 2 No
the Maryland a or 28a-f sh tified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
h the 13a or lotifie	2012 Madison Ave 21217 USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify. Specify: Black W
ntural" atural" d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done  16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
15-0036 Ted within 7 Hygiene d other than the Medica	12th Computer Technician Private Innustry
215-C be filed v ntal Hygi rked oth ent, the	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Mary Johner
ID 21215-00; should be filed with and Mental Hygiene? is marked other that event, the Meronardic event, the Me	19a Informant's ame/Relationship (Type Print )
e, MD 21215-0036 I and 2 should be filed within 72 hours after Health and Mental Hygene iten 27 is marked other than "natural".  To Be Completed by	Morgan nawings \ 1432 W Earvale St Battimore Ad 21211
re, M s 1 and 2 f Health If item 2'	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
imore Pages 1 ment of H tant: If i	4 Donation 5 Other Specify: Gennound metery 9/25/06 Baltimore Md.
Baltimore, permit Pages I an Department of Hea Important: If iter	21. Signature of Funeral Service gensee 22. Name and Address of Facility Chatman-Harris Funeral Home
Physician	23a. Payl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart.  Approximate Interval.
/Medical	Mailure. List only one cause on each line  Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
	Sequentially list conditions, b.
ted Insit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
sd sit	events resulting in death) Last  Due to (or as a consequence of):
n and lad trait	y UNPENDED Y AMENDED #10. 1 TH CO TITL OF CO 10/4/00 THE
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23a,PII,27,28a-f,perME,g860,10/4/06 TT 23c. If yes, outcome of pregnancy 23d Date of delivery
587( rrifica ling pt as the	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 687 e death certific the attending p ed for use as th	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown
D. Bc I the dea by the a sched fo	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e Did tobacco use contribute to the cause of death?
P.C es that igned be deta	Atherosclerotic cardiovascular disease 1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires ficate has been signed. page 2 should be Completed	24a Was an 24b Were autopsy findings available
eco ne law te has ge 2 s	autopsy prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rs after death.  Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly entification: To Be Completed by P	25. Was case referred to medical 26.Place of Death (Check only one)
Vita hysici this co	examiner?  1  Yes 2 No    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other
n of N ding Ph. After tl funeral on: T	27. Manner of Death  28a Date of Injury (Month, Day Year)  1 Natural 5 Pending  28a Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  28d Describe how injury occurred
Sior Attend death ector: by the	2 Accident Pending Investigation Fnd 9/16/2006 Fnd 8:05 am Pending Investigation Inves
Division o spiral or Attending nours after death. Infilled in by the function: After the control of the control	3 Suicide 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found on a park bench 28f Location (Street and Number or Rural Route Number City Ballows, State) Place
Lospit 4 hour 7 umers 1 Ce	29a Certifier
To the He within 24 To the Fu completel	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Me Report	29b. Signature and title of certifier     29c License number     29d Date signed (Month, Day, Year)
	0.C.M.E. September 16, 2006
7	30. Name and address of person who completed cause of death (Item 23a)
tt	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature
DHMH 17 Rev 1/2001	ORIGINAL
0.0115.0000	ONORME

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#31 perDVR C859 9/26/06 WS
State of Maryland P Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1205PM **Physician** TT 2006 LONGEST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 19, 1933 BALTIMORE, MD Johns Hopkins Bayview 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F Months Maryland 219-30-5375 73 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours after death with the Marylan thit and Mental Hygiene. 27 is marked other than "natural; or Items 23a or 28a-1 ehow traumatic event, the Madical Examiner matter notified at Maryland Baltimore Dundalk 1 ☐ Yes XXNo Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8016 Wynbrook Road 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland Casualty Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry O. Kavanaugh Mamie Tee ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If item 27 is rr any injury or other traum <u>once.</u> Vernon E. Longest Husband 8016 Wynbrook Road, Dundalk, Maryland 3altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 9/27/2006 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road Baltimore, Maryland 21. Signatur Ineral Service Ucen ee 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracravial bleed **Physician** /Medical Due to (or as a consequence of): Examiner Hypertension
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine been signed by the attending physicien and should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the autopsy performed? 1 ☐ Yes 2X No 1 ☐ Yes 25 No : After this certifical funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-001 Maney 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

4940 EASTERN AVE BALTIMORE, MD 21224

DUHANEY

SEP 2 6 2006

32. Registrar's Signature

2 mars

20BEIL

31. Date filed (Month, Day, Year)

			For State Registrar	State o	of Marylan		artment tificate			and M	-	-	2006	30444
	Physici /Medic		Decedent's Name (First, Middle,	PATR	CIA	RUTH		ЬЬС	YD		2. Date of De Month	Day	Year 2006	3. Time of Death 12:45 A M
	Examin	er	4a. Facility Name (If not institution, WESTMINSTER	NURSING	HOME		WES	rmi	Location o	3		C	County of Death	h L
	Funeral Director		5. Social Security Number  238-38-1158  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. I	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birti Co MAR	nplace (State or Foreign untry) YLAND
	with the Maryland a or 28a-1 show be notified at	ctor	10a. State 10b. County  MD CARF	ROLL		y, Town or Lo		GE						10d. Inside City Limits 1X Yes 2 □ No
	ath with the 23s or 28 itst be no	rai Director	10e. Street and Number 26 S. MAIN S	Т.			10f. Zip		791			10g. Citiza	en ol What Co	untry?
2-0036	after de or Itame	by Funerai	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☒ Widowed 4 □ Divorced	Armed Fo	ve		Was Deced I Yes, spec I □ Yes 2		ispanic Origin, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: WH	
0-61212	within 72 hours iene. then "natural", ite Medical Exa	Completed	15. Decedent'. (Specify only highest Elementary/Secondary (0-12) 1 2	Education grade completed) College (	1-4or 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	k done d e retired	during most		ng		d of Business/i	RVICES
yland	ould be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, L	charles	ROBIN	ISON	01101		18. Mothe		(First, Middle		Sumame)	
e, Mar	s 1 and 2 shou f Health and M Item 27 is marl other traumati		19a. Informant's Name/Relationshi				S. M	AIN	ST.	,UN	ION BE	RIDGE		21791
IIIMore	att. Pages artment of h ortant: If its njury or of		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other (Sp.  21. Signature of Funeral Service ↓	3 □Removal from ecity)	State SOUT	emetery, cren H CARI	natory or of ROLL	CRI	EMAŢC	9/26 DRY		WINF:	IELD,	MD
e E	Department of the population o		23a. Part1. Enter the disease, or shock, or heart lailure. Use o	the	caused the death	2.	54 E	. M	AIN S	ST.,	WEST	MINS	ERAL H	ID 21157 Approximate
	nysician /Medical Examiner		snock, or neart failure. Lest of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a Co Due to b Q	(or as a consequ	uence of):					dre			Interval Between Onsyl and Death
8/00, C	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Ll	(or as a consequ (or as a consequ	2								30yr
. Box 6	death certiti e attending i d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ➡No 9 ☐ Unknown	1 ☐ Live I	tcome of pregna birth 2 Tetal nant at time of de own	death 3	Ectopic pre					23	3d. Date of deli Month	very Day Year
ecords, r	law requires that the as been signed by the 2 should be detache	ا ۾	Part II. Other significant condition	s contributing to d	eath but not resu	ulting in the ur	nderlying ca	use give	en in Part I.		23e. Did t			the cause of death?
Hecc	the law recate has be page 2 shi	Completed						· · ·			24a. Was autor perfo		24b. Were autoprior to death?	topsy findings available ompletion of cause of
	certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	) C'		Check only o			
VISION OF	To the hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ertification: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon		ER/Outpatien 28b. Time of Injury		lc. Injury Work	4 1901	2	ne 5 🗌 Resid		Other (Spec	ity)
DIVIS	ital or Atteurs after de ral Directo	O	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place build	of Injury - At ho ing, etc. (Specify	()					City or To	wn, State)		ral Route Number,
	the Hosp hin 24 hou the Fune Tipletely fi	Medical	one) 2   Medical E	Physician: To the xaminer: On the b and man	best of my know asis of examinat ner stated.	wledge, death tion and/or inv	estigation,	in my of	oinion, deat	d place, a h occurre	and due to the ed at the time,	date and p	place, and due	to the cause(s)
	Tw F	_	29b. Signalure and title of certifier	Mhr	in mi		D	25	o number	3			signed (Month)	
	2		30. Nam d address of person w	ho completed cau:	se of death (Item	23a) (Type, 1	Print)	,	11.	han .	a cho	1	1 10 .2	1157
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 6	2006	legistrar's Signal	ture	and I	<del>)</del>	ry 191	· FF( )	-10/61	1		

Physic	an	1. Decedent's Name (First, Middle Clara B. McKinley	31 Per DVR						2. Date of the Month	Death Day 22	2006	3. Time of Death 7:05 PM
/Medi	cal	4a. Facility Name (If not institution,	give street and number	ar)		4b. City. To	wn. or Loc	ation of Dea			County of Death	
Examir	ier	5803 Woodsrest Ave		,		Ba1	timore	City			n/a	а
Funeral Director		5. Social Security Number 213-12-6950	6. Sex 1 ☐ M 2 🟋 F	Age (In yrs. I	ast birthday) 38 Yrs.	If Under 1 \ Months D		Under 24 Hr ours Mir		Birth 13/1918	9. Birth Cou	place (State or Foreign intry) MD
<b>*</b>		Usual Residence of Decedent  10a, State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits
e p	ō	MD n/a			Baltimor							1 <b>X</b> Yes 2 □ No
a or 28a	Direc	10e. Street and Number 1111 Park Avenue				10f. Zip Co		1201		10g. Citi	zen of What Cou	intry?
the Medical Exeminer navit be putified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force ed 1 Tyes Cive If Yes, Give Year or Date:	s? XINo	1	as Deceden Yes, specify		nic Origin? ( lexican, Pue pecify:	Specify Yes or Into Rican, etc.)		14. Race - Amer Black, White Specify: Blac	, etc.
edical E	Completed t	15. Decedent (Specify only highes	s Education f grade completed)		16a. Decede (Give k life. D	ent's Usual C ind of work of ONOT use	Occupation done during retired)	n ng most of w	orking	16b. Ki	nd of Business/li	ndustry
ā	E	Elementary/Secondary (0-12) 12th	College (1-4d	or 5+)		Cla:	ims Au	thorize	r	Fed	eral Gove	rnment
vent,	To Be C	17. Father's Name (First, Middle, I	ast)					Mother's Na Julia S	ame (First, Midd Sembly	lle, Maiden	Sumame)	
y or other treumatic ev		19a. Informant's Name/Relationsh Brenda McKinley /			•	,			Ru <i>ral Route Nun</i> <b>more, M</b> D		r Town, State, Zi	ip Code)
other	-	20a. Method of Disposition		20b. P	lace of Dispos emetery, crem	ition (Name atory or othe	of er place)		Date	20c. Lo	cation - City or T	Town, State
ury or		1 ☐Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		ite	odlawn Ce	emetery		-	28/2006	_	lawn, Mar	yland
importent: if item 2 eny injury or other once.		21. Signature of Funeral Service	icasee	)					lylie Fund Baltimon			
ician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. CASM	u ca	ner	r the mode o	of dying, s	uch as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
dical iner		,		as a consequ	uence of):							
lis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	uence of):							
ne burial-transit	ical Examiner	that initiated events resulting in death) Last	c. Due to (or d.	as a consequ	uence of):							
ched for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	n 2 □ Fetal t at time of de	J déath 3⊡t	Ectopic preg Other (spec				-	23d. Date of deli Month	very Day Year
d be detached t	þ	Part II. Other significant condition	1	h but not resi		derlying cau	ise given i	n Part I.	1			the cause of death?
has been sig e 2 should t	Completed		1 7		7.7.					as an topsy rformed?	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
this certificete has al director, page 2									1 ☐ Yes	2000	1 Yes	2 No
recto	Be	25. Was case referred to medical examiner?	Hospital:	O 🗆	ER/Outpatient	2 DOA	Othor		eath (Check on)		6 □Other (Spec	(£.)
aral di	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of 1 (Month,		28b. Time of		c. Injury at Work?	4   Nursing	28d. Describ			ary)
in by the tuneral	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could in 4 Homicide determine	pation and the 28e. Place of		Injury ome, farm, stre	М	1 🗌 Yes	2 □No	28f. Location City or	n (Street an Town, State	d Number or Ru )	ral Route Number,
to the Funeral I	edical C	29a. Certifier Check only 2 Medical	Physician: To the be Examiner: On the basis	s of examina	wledge, death tion and/or inv	occurred at estigation, in	the time,	date and pla on, death oc	ce, and due to to curred at the time	ne cause(s) le, date and	and manner as I place, and due	stated. to the cause(s)
completely tilled in by	Med	29b. Signature and little of certifier		Mo			License ni			29d. Dat	te signed (Month	n, Day, Year)
		30. Name and address of person		of death (Item	n 23a) (Type, F	Print)	1	4.1	md vi			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200530446 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** September, 23, 2006 4c. County of Death 10:55 PM WANDA MENSAH /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sanit Agnes Social Security Number 214-82-2153 Ballimove
If Under 1 Year | If Under 24 Hrs. Huspital 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 12KF Yrs. Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23s or 28s-1 ehow with injury or other traumatic event, the Maudical Exprimer must be notified at once. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1⊈Yes 2 No MARILAND **Funeral Director** 10e. Street and Number 10g, Citizen of What Country? AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN URS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NANCY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. BALTO. MD. 21223 ANCY YOUNG 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CARMEL CEME 09-4 ☐ Donation 5 ☐ Other (Specify) 21. Signature et Euneral Service Licensee 22. Name and Address of Facility

2140 N. Ful BROWN JR. FUNERAL HOME TON AVE. BALTO. Mp. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) septic **Physician** Shock 01 /Medical Due to (or as a consequence of): Examiner Metabolic acidosis 01 structure in the structure of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit 01 spiratory IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No ndrome Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physicien: The law within 24 hours after death.
Othe Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy performed?

1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Naturai 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mana Manbret 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

3

Mens

SEP 2 6 2006 Registrar

900 31. Date filed (Month, Day, Year) Baltimore

Maryland

Ave

32. Registrar's Signature

Catons

			1 - State Registrar	State of Maryland		artment of F			Reg. No. 2	006	30447
	Physici /Medi	cal	Decedent's Name (First, Middle, Last)  NANCY  L  Management  4a. Facility Name (If not institution, give stre	TARTO		4b. City, Town, o	r Location of Dea	2. Date of De Month	Day 23	Year OG unty of Death	3. Time of Death
· ·	Examir	ier	BAYUSW HOSPY  5. Social Security Number 6. Sex	tal	and birth day	0.1	1 If Under 24 Hr		C	Satrino	re City
	Funeral Director		219-50-2168 Usual Residence of Decedent	7. Age (In yrs. II	Yrs.	Months Days	Hours Mir			Mary	place (State or Foreign Intry) 1 Land
	Aarytand f show	ō	10a. State 10b. County MD n/a		, Town or Lo ltimor						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-	Direct	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	**
36	s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itama 23e or 28e-f show other traumatic event, the Madical Examiner must be notified at	by Funeral Director	3807 Mount Pleasant  11. Marital Status  1  Nover Married 2 Married  3  Widowed 4 □ Divorced	. Was Decedent Ever in U.S Armed Forces? 1   Yes 2 M No If Yes, Give Year or Dates:	1	2122  Was Decedent of H  f Yes, specify Cuba  □ Yes 2⊠ No		Specify Yes or No- into Rican, etc.)	- 14.	d Stat Race Amer Black, White ecify: Wh	ican Indian, , etc.
21215-0036	within 72 hou ene. then eneture	Completed	15. Decedent's Educat (Specify only highest grade c	tion	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of w	orking	16b. Kind	of Business/li	ndustry
Maryland 2	wild be filled Mental Hygie srkad other stic event, It	To Be Co	17. Father's Name (First, Middle, Last) William Martin		51545			<sub>ame (First, Middle,</sub> rehearn			
	nd 2 should lih and Men 27 is marka r traumatic		19a. Informant's Name/Relationship (Type) Janet E. Speake/Sist	. ,				Ru <i>ral Route Numbe</i> ve. Balti			
Baltimore,	permit. Pages 1 end 3 Department of Health Important: if Item 27 any injury or other tri <u>900@</u> .		20a. Method of Disposition  1 Burial 2 Termation 3 Rem  4 Donation 5 Other (Specify)	20b. Pl	ace of Dispo emetery, cren St Arui	sition (Name of natory or other place ndel Crem	atory 9	Date -25-2006	20c. Locati Odent	on - City or T	own, State ryland
Balt	permit. Departr importe any inje		21 Signature of Funeral Service License	Suches	7 2	719 Hammo	nds Fer	ry Rd. La	ansdow	Home ne MD	of Lansdown 21227
8760,	Physician / Medical Examiner	icai Examiner	23a. Pan1. Enter the disease, or complicate shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to annieurate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to	ence of):		g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed for the hes been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnar  1 Live birth 2 Fetal  4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d.	Date of deliv Month	ery Day Year
О.	quires that n signed build be deta	þ	Part II. Other significant conditions contrib	buting to death but not resu	lting in the ur	iderlying cause give	en in Part I.		bacco use d		he cause of death?
al Records,		Completed	НТИ					24a. Was a autop perfor	sy	No. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
	ysician is certifi director	To Be	25. Was case referred to medical examiner?  1  Yes No	pital: 1 ☐ Inpatient	R/Outpatien	t 3□ DOA Othe	or	eath <i>(Check only or</i> Home 5 - Resid		Other (Speci	(v)
Division of Vital	ng Ph fter th ineral	Certification: 1	2 ☐ Accident investigation		28b. Time of Injury	28c. Injun World		28d. Describe h			<i>'</i>
<u>X</u>	e giri		4 Homicide	28e. Place of Injury - At hor building, etc. (Specify,	)			City or Tow	n, State)		al Route Number,
	the Hospital in 24 hours a tha Funerel i pletely filled	Medicai	(Check only 2   Medical Examiner one)	ian: To the best of my know : On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occ	e, and due to the durred at the time, d	ause(s) and date and place	manner as s ce, and due t	stated. o the cause(s)
)	To the within 2 To the complet	2	29b. Signature and title of certifier			29c. License	3350	4	29d. Date sig	ned (Month,	Day, Year)
	3			bell BlvD		Print) 8	pltimar	e MD	2123	5	
ı	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2006	32 Registrar's Signati	ure	1					

	1	Stewart 41	ec Ple			Print in									
UNK UNK		Sta I- For State	te of Ma	ryland		rtment o tificate o			d Menta	ll Hygiene	<b>.</b>	20	10	5 30	1.1
Physicia		Registrar 1. Decedent's Name (First, Middle,		-			Dour			2. Date of D	Reg. No eath			Time of Death	-
Medical Examin		Pau1 S  4a. Facility Name (if not institution,	tewar		Mil	ler	4h City	Town or	Location of I	Month Septem		, 2006 c. County of De		0105 hrs	
1		West bound 50 mile ma		ina number,				onburg		Joan		Wicomico	-GUI		
Funeral		5. Social Security Number 6	. Sex	7. Ag	e (In yrs. la	st birthday)	If Und	er 1 Yea is Day		Min. Nov3		WDD/YYYY) g.		ace (State or Maryla	ba
Director	ļ	217-46-1760   Usual Residence of Decedent	1 X M 2	F	56	Yr				NOVS	,,,	949	Countr	ylal yla	HIG
v any	Ì	10a. State 10b. County		-	10c. City,	Town or Loca	ation							d. Inside City L	
yland i-f shov	ģ	Md. Har	ford		F	orest	Hil 10f, Zip				I 10a Ci	itizen of What C		Yes 2 X	INO
vith the Maryland s 23a or 28a-f show a	Director	1805 Bear Cr	eek D	rive					50-27	01		USA	,		
h with t ms 23a be not	Funeral	11. Marital Status	Α	as Deceden						? ( Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ar White, etc		Indian, Black,	
er death		Never Married 2 Mar 3 Widowed 4 Divo	ried 1 X	Yes 2			Yes 2	_		, ,		Specify: Wt	nit	e	
ours afi atural' xaming	d by	15. Decedent's Education (Speci	or Dates	E	mpleted)	16a. Decede	ent's Usual	Occupa		nd of work done	16b.	. Kind of Busine			
336 thin 72 h ne. than "n	plete	Elementary/Secondary (0-12)	Col	ege (1-4 or 4	5+)	J	lice			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	C	ity of	: B	altimo	re
5-0036 fled within 77 Hygiene. I other than	Completed	17. Father's Name (First, Middle, I								Name (First, Middl				a L C I III.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Be	Melvin Stew  19a. Informant's Name/Relationsh		Mill	er	10h Mailu	ng Addres	s (Stree		leanor		im City or Town S	tate 7	in Code)	
s, MD 2121 and 2 should be fi lealth and Mental tem 27 is marked traumatic event,	٤	Karen A. Mil			)		_	,		Drive					)50
re, N s J and f Healt If item		20a. Method of Disposition  1 Burial 2 Cremation	3 Rem	oval from S	ate c	Place of Disportenatory or of	other place	)		Date		c. Location - City	or To	wn, State	
Baltimore, permit. Pages I an Department of Hea Important: If the		4 Donation 5 Other Spe	ecify:		Bay	yview				9-26-06 aczorow		altimo			
Balt permit Depart Impor		21. Signature of Funeral Service L	(i).	2						Ave. Ba					
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of	omplications	hat cause	the death.	Do not enter	the mode	of dying	, such as car	diac or respiratory	arrest, s	hock, or heart		Approximate In Between Onse	
/Medical raminer		Immediate Cause (Final disease or condition resulting in death)		e inhalati or as a cons			uries in a	associ	ation with	chest injuries			$\dashv$	Death	
K		Sequentially list conditions,	ь										$\dashv$		
	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to ( c.	or as a cons	equence of	·):									
cuted and transit	Exa	events resulting in death) Last	Due to (	or as a cons	equence of	f):									
\ 3 \ \ \ \ 3	=	UNPENDED	AMEN	IDED											
Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the		If yes, outco	me of pregr		etal death	3	Ectonic	pregnancy	2	23d. Date of deli Month	ivery Day	/ Yea	ır
x 68 th certi	siciar	past 12 months?  1 Yes 2 No 9 Unk	4	Pregnant a	t time of de	oth _	Other (Spe		Lotopio				,		
). Bc the dea by the a	Phys	Part II. Other significant condition	9	Unknown uting to dea	th but not re	esulting in the	e underlyin	g cause	given in Part	I. 23e. D	id tobacc	co use contribut	e to the	e cause of deat	:h?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the 1s after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d by	Hypertensive Atheros	clerotic C	ardiovaso	cular Dise	ease				1	Yes 2	No 3	Probab	oly 4 🗸 Unkr	iown
ords w requi	Completed										as an utopsy erformed	prior	r to con	osy findings ava npletion of caus	
Rec The la ficate h	Com								(5) (1)	1 🗸 Y	es 2		Yes	2 1	No
/ital sician: is certil	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital	1 Inpat	ent 2	ER/Outpatie	nt 3	DOA	Other:	Nursing Home 5	Resi	dence 6 🗸 C	Other: S	Scene	
Of \ing Phy	$\vdash$	27. Manner of Death	288	a. Date of In (Month, Day ep 21, 200	jury Xear)	28b. Time o	f Injury		ury at Work?	Driver of		njury occurred	hich i	nvolved fire	e
Sion Attend death. ector: by the f	Certification:	1 Natural 5 Pend 2 ✓ Accident Inves	tigation			ome, farm, st	reet factor		Yes 2 V		n (Stree	t and Number o	r Rurai	Route Numbe	r. City
Divisior  Hospital or Attend 24 hours after death Funeral Director: stely filled in by the 1	ertifi		not be	pecify) M				,,		or Tow	n, State)				
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the l		29a. Certifier 1 Certifying Phone) 2 Medical Exam	ysician: To	the best of a	ny knowled	ge, death occ	curred at th	e time, o	date and place	e, and due to the d	ause(s)	and manner as	started	t. cause(s)	
To the within To the comp	Medical	29b Signature and title of certifie	and m	anner stated	l.				se number			d. Date signed			
	_	Dt. Our	m. 14	-48	PDL			O.C	.M.E.		Se	eptember 2°	1, 200	06	
154		30. Name and address of person				23a) Examiner	111 5	Penn S	Street Ral	timore, MD 21	201				
	ate	Patricia Aronica-Pollal  31. Date filed (Month, Day, Year)		- III			Acark	SIII S							
Regist		31. Date filed (Month, Day, Year) SEP 2	6 2008	De	ASIAS	ire /	A CONTRACTOR OF THE PARTY OF TH								

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 23, DONALD CAPLES MARTIN SEPT 2006 6:33 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PLEASANT VIEW NURSING HOME MT. CARROLL AIRY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 88 Director 213-01-9165 9/22/1918 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 □ No MD CARROLL WESTMINSTER Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 94 E. MAIN ST. USA filed within 72 hours after death Hygiene. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. ğ Specify: Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN AUTOMOBILE 11 of Heelth and Mental Hygie item 27 is marked other permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Importent: If Item 27 Is marked otherly injury or other treumatic avent, 9069. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN C. MARTIN VIOLA MAE CAPLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY M. COYLE - DAUGHTER 418 HOOK RD., WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 152 Burial 2 ☐ Cremation 3 ☐ Removal from State KRIDERS CEMETERY 9/26/06 □Donation 5 □Other (Specify) WESTMINSTER, MD Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician VIYOCARDIAL INFARCTION /Medical resulting in death) Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physician and the for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 1 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à LLCER DIJEATE 2 **N**O 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? SENILE DEMENTIA 24a. Was an autopsy performed? 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ENatural 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. within 2

State Registrar 31. Date filed (Month, Day, Year) SEP 2 6 2006

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IV B VELLANK, \$5.50, COLUMBIA, 100 8850 COLUMBIA 32. Registrar's Signature

100

29c. License number

D. 30469

Parkerey.

29d. Date signed (Month, Day, Year)

40-21045

September 25,

# 308. Columbia.

	,		1 - For State of Maryland / De State of Maryl	epartment of Health and M Dertificate of Death	ental Hygier	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  TO SEPH MANN		2. Date of Death Month DEPTEMBER	Day Year 3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)  NORTHWEST HOSGITAL CENTE	4b. City, Town, or Location of Death	4	1c. County of Death BALTIMORE.
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birth 83 Yr	Months Davs Hours Min.	8. Date of Birth Month, Day, Yea 01/13/192	9. Birthplace (State or Foreign Country) GERMANY
	yland low		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	Ba-fet	ctor		LTIMORE		1 ☐ Yes 2 No
	with the	Funeral Director	10e. Street and Number 6401 BEDFORD AVENUE #506	10f. Zip Code 21208	10g. (	Citizen of What Country?  USA
	ems 2	inera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spei If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian, Black, White, etc.
3036	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow deat Examiner must be motified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No WW II I 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: WHITE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Modical Examinatment be rediffed at once.	Completed	(Specify only highest grade completed)  (Specify only highest grade completed)  (College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of workin fee. DO NOT use retired)	9	Kind of Business/Industry
d 21	filed w Hygier other tl		12 BAK 17. Father's Name (First, Middle, Last)		(First, Middle, Maide	KERY en Sumame)
ylan	Mental Mental Brked o	To Be	EDWARD MA	NN LOUISE		BAER
Maryland	nd 2 sho Ith and 27 is m			Mailing Address (Street and Number or Rural KNIGHT COURT - REIS		
	es 1 ar of Hea of item?		20a Method of Disposition 20b. Place of D			Location - City or Town, State
Baltimore,	it. Pag rtment rtant: I njury o		`4 □Donation 5 □Other (Specify)	MEDROSH HAGADOL 9/25	1	OSEDALE, MD
Ba	permi Depa Impo any ii		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL 8900 REISTERSTOWN R		& BROS., INC. FSVILLE, MD 21208
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac or		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a			Onsot and Seath
ŀ	Examiner	_	Sequentially list conditions.			
	uted J ansit	Examiner	Cause (Disease or injury	:		
, 00,	icate be executed physician and s the burial-transit		resulting in death) Last C. Due to (or as a consequence of			
68760,	ficate b physic s the b	edica	d.			
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	res that igned b	by	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.		o use contribute to the cause of death?
ord	w requir been si should	eted	CEREBROVASCULAR ACCIDENT	. 0	1 🗆 Yes	
Rec	The law te has I	Completed	DIRBETES PARLUTUS TYS	ASE.	24a. Was an autopsy performack	24b. Were autopsy findings available prior to completion of cause of death?
/ital	clan: " ertifica octor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death		No 1 ☐ Yes 2 ☐ No
of \	Physic this cral dire	2	1 ☐ Yes 2 No Hospital: 1 Anpatient 2 ☐ ER/Outp		e 5 Residence	6 □Other (Specify)
ion	Attending death. ctor: After y the fune	ation	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation		od. Dodolibo flow anj	ary occurred
Division of Vital Records,	after Dire	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	s, street, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital within 24 hours to the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, one)  1 Medicel Examiner: On the basis of examination and/and manner stated.	feath occurred at the time, date and place, as prinvestigation, in my opinion, death occurre	nd due to the cause( d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
)	To the within to the comp	M	29b. Signature and title of desirifier 7th 7H 4SICIAN	29c License number D 4 2723	29d. D 58 (*	nd place, and due to the cause(s)  Date signed (Month, Day, Year)  TEMBER 22 2006
	10		30. Name and address of person who completed cause of death (Item 23a) (Tr. AVVERAKALLI M HARISH	700, Print) NONTHWEST 5401 OLD (	HOSPITAL	CENTER MD 21133
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 2 6 2006  32. Registrar's Signature			
DH	MH 17 Rev 1/20		AFL HO COAD Company	JORGE J		

			1 - For State Registrar		State of	Marylar		artment of H rtificate of L		Mental Hyg	ene g. No. 20 (	)6	30451
П	Dhysiai		1. Decedent's Name (Firs	st, Middle, Las	st)					2. Date of Death		Year	3. Time of Death
	Physici /Medio		Frances	s Ada I	Vewman					Sept 20	2006	real	7:38 А м
	Examin		4a. Facility Name (If not in			nber)		4b. City, Town, or	Location of Death		4c. County o	f Death	
			6101 Bard	ley Lar	ne			Clinton			Princ	e Ge	eorge's
	Funeral Director		5. Social Security Number 214 36 4218		ex □ M 2√√√F	7. Age ( <i>In yr</i> s. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 16	Year)	Coun	place (State or Foreign htty) Land
	pu		Usual Residence of Dece										
	arylar show	_		County			ty, Town or Lo	cation				1	0d. Inside City Limits
	Ba-f	Director	Maryland   Pr	rince (	George's		Clinto	on					1 ☐ Yes 2 ☐ No
	or 2	-ic	10e. Street and Number	D				10f. Zip Code		10	g. Citizen of Wh	nat Coun	itry?
	23a		9101	Bradle	y Lane			20735	5		United	Sta	tes
36	d within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-1 show the Medical Exar.il armust be indiffed at	by Funerai	11. Marital Status  1 Never Married		12. Was Dece Armed For 1 ☐ Yes If Yes, Give	ces? 2 XNo	1	Was Decedent of Hi f Yes, specify Cuba I □ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		White,	etc.
8	hour		3 □ Widowed 4 □ D		Year or Da	ites:					Specify:		
5	"nat	Completed	(Specify on	ecedent's Ed Iy highest gra	lucation de completed)		(Give	lent's Usual Occupa kind of work done of	uring most of wor	rking	6b. Kind of Bus	iness/Ind	dustry
12	within lene. • than "	ш	Elementary/Secondary 7th	(0-12)	College (1-	4or 5+)		OO NOT use retired,					
2	be filed ntal Hygid of other	e Co	17. Father's Name (First,	Middle Last)			HC	memaker	18 Mother's Nan	ne (First, Middle, N	Own Home		
an	be pd o	B	John Newm								alden Surrame,	,	
Z	should the marker thanks are marker are are are are are are are are are a	2	19a. Informant's Name/R		Tuna Print)		10h Mailie	a Address (Street a		y Butler  ural Route Number,	0:	7	2-11
Maryland 21215-0036	d 2 sho		Joseph H. N			d )				inton, MD		tate, Zip	Code)
	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		20a. Method of Dispositio		(IIII)			sition (Name of	iane, CII		20735 0c. Location - C	ih, or To	eun Stata
٥	Pages nent of int: if its iry or o		1 ∏ Burial 2 □ Crei	mation 3 🗆		State	cemetery, cren	natory or other place		-		•	·
Baltimore,	nit. Pa partmen ortant: injury	. 4	°4 □Donation 5 □0			N.	esurrec	tion Ceme	tery Ser	ot 27,200	o Clinto	on, l	Maryland
Ba	permit. Pages 1 a Department of Hee important: if itam any injury or otha		21. Signature of Furreral	III.	wh p	10019	53 A	lexandria	Ferry R	e Funeral Rd, Clinte	Home,Ir on, MD 2	ic 66 2073:	<b>533</b> 01d 5
			23a. Part1. Enter the disc shock, or heart failu	ease, or comp re. List only	olications that ca	used the dear	th. Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Athe		east x	Canh	SILLACO	las He	at Di	ر مان ان	Onset and Death
	/Medical		resulting in death)		a Due to (	or as a consec			-C V-43 CC	110.		1	
	Examiner		Sequentially list condition		b								
	ס =	Examiner	If any leading to immedia cause. Enter Underlying	ita J	Due to lo	or as a conse	uence of						
10.	acute and trans	E	Cause (Disease or injury that initiated events resulting in death) Last		c.								
Ő,	e exectan a	Ě	resulting in death) Last		Due to (d	or as a consec	(uence of):						
68760,	ificate be executed g physiclan and as the burial-transit	edicai			d.								
_		Me	IF FEMALE:										
Вох	that the death certified by the attending detached for use a	Physician/M	23b. Was decedent pregr in the past 12 month	idill		rth 2 ☐ Feta	il death 3	Ectopic pregnancy			23d. Date Month		ry Dav Year
	0 0 T	Sic	1 ☐ Yes 2 🏋 No 9 ☐ Unknown		4□Pregna 9□Unkno	int at time of c wn	leath 5□	Other (specify)			World		Day real
P.O.	law requires that the as been signed by th 2 should be detache	Ph				-4h h . 4 - 4	detail to all			OR DILL			
	res that signed b	by	Part II. Other significant	conditions c	ontributing to dea	ath but not res	sulting in the ur	iderlying cause give	n in Part I.				e cause of death?
orc	w require been sig should b	ted	····							1 L Yes	2 □ No 3	☐ Proba	ably 4 known
Vital Records,	has by	Completed								24a. Was an autopsy	24b. We	re autop	osy findings available inpletion of cause of
<u>س</u>	Th ate	50								perform	ed?dea	th? Yes	
/ita	Physician: this certificatal director,	Be (	25. Was case referred to examine?	medical					26. Place of Dea	th (Check only one	)		
of <	hysic his ce I dire	၉	1 Yes 2 No		Hospital: 1 ☐ In	patient 2	ER/Outpatien	3 □ DOA Othe	. 4 🗌 Nursing H	ome 5 Resider	ce 6 Other	(Specify,	)
	ng Pl fter tl		27. Manner of Death	Pendina	28a. Date of (Month)	f Injury , Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	v injury occurred		
0	Attanding r death. sctor: After by the funer	atic	2 Accident	investigation					es 2□No				
Division	or Att	Certification:	3 Suicide 6 4 Homicide	Could not be determined	289. Place	of Injury - At he	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,		or Rural	Route Number,
	ital or its af rai D led ir								l l				
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funarai Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 0 C (Check only one) 2 1	ertifying Phy ledical Exam	ysician: To the t iiner: On the ba and mann	sis of examina	owledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	, and due to the cau rred at the time, dat	rse(s) and mann e and place, and	er as sta d due to	ited. the cause(s)
	To t To tl	Ž	29b. Signature and title of	certifier	1.	-		29c. License	number	29	d. Date signed (	Month, D	Day, Year)
			Aul	valor	/hlv	370.	20	1.6	00533	777 5	esto.	ula	122 Zaice
	6	Ì	30. Name and address of	person who	completed cause	of death (Iten	n 23a) (Type, I	Print)			2000		
	~		SALVAD	or 5.	1881-	V 300	x Ho	spital	Drins	y Ch	-ml	it.	any Good
	Sta		31. Date filed (Month, Day	v, Year)	32. Re	gtstrar's Signa	ature	0			01		,
	Registra	ar	SE	P267	2006	Pallace a	M. E.	CONTRACT !					

			1 - For State Registrar	State of Maryland		rtment of Hetificate of L			ene g. No. 2006	30452
	Physici /Medic		Decedent's Name (First, Middle, Last)     YOLANDA	ORTIZ				2. Date of Death Month Septembe	r <sup>Da</sup> l6, 2006	3. Time of Death 11:30p M
	Examir		4a. Facility Name (If not institution, give 12000 Dove Circle			4b. City, Town, or Laurel			4c. County of Death Prince Ge	orge's
	Funeral Director		5. Social Security Number 6. Security Number 098-56-2816	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, 1 March 4,	1963 9. Birth Cou Pu	place (State or Foreign intry) erto Rico
	Maryland -f ehow	tor	10a. State 10b. County  MD Prince Ge		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2☐ No
	h with the 23s or 28s	al Director	10e. Street and Number 12000 Dove Circle			10f. Zip Code 20708	3	10	g. Citizen of What Cou	
36	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or items 23a or 28a-1 show avent, I're Madical Examinat Ive motified at	by Funeral	11. Marital Status  1 ☐ Never Married 2☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  ☐ Yes 2  M No If Yes, Give Year or Dates:	11	Vas Decedent of His Yes, specify Cubar X Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify: Pue:	Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	within 72 houene. than "natura	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) Grade 12	cation e completed) College (1-4or 5+)	(Give )	ent's Usual Occupa kind of work done di OO NOT use retired) School Te	uring most of work	ng 16	6b. Kind of Business/I	
and 2	ould be filed v Mental Hygie arked other I atlc avant, II	Be	17. Father's Name (First, Middle, Last) Angel Luis Ortiz		Pre-		18. Mother's Name Dominga		Education aiden Surmame)	
Mary	d 2 sh th and 7 la m traum	7	19a. Informant's Name/Relationship (Ty	•		g Address (Street a	nd Number or Rura		City or Town, State, Z	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat <u>once</u> .		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 区路 4 □ Donation 5 □ Other (Specify)	emoval from State	e of Dispos etery, crem	sition (Name of natory or other place nds Cemet	p)	ate 20	Dc. Location - City or I	own, State
Balti	permit. Departm Importa any inju		21. Signature of Funaral Service License		22 D	Name and Address onaldson 13 Talbot	s of Facility Funeral I	Home, P.A		20707
The state of the s	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Liver Failu	re	er the mode of dying	, such as cardiac c	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Examiner	ler	Sequentially list conditions,	Due to (or as a consequent as a Canc Canc Cue to for as a consequent	er					
68760,	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):					
P.O. Box 68	death certiff e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of delin Month	very Day Year
	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II, Dther significant conditions cor	stributing to death but not resulti	ng in the un	derlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records,	: The law recate has be page 2 sh	Completed						24a. Was an autopsy performe 1 ☐ Yes 2X	prior to co	opsy findings available ompletion of cause of
<u> </u>	Physician: r this certifica ral director, i	Ве	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death			
ion of	ing After une	atlon; To	1 Yes 2XXvo  27. Manner of Death  1 XXiatural 5 Pending 2 Accident investigation	1 Unpatient 2 LEF	VOutpatient Bb. Time of Injury	28c. Injury Work	4   Nursing Hor	ne XXResiden 28d. Describe how	ce 6 Other (Special injury occurred	(v)
Divis	tal or Attend rs after death al Director: ,	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				City or Town,		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	estigation, in my opi	inion, death occurre	ed at the time, date	e and place, and due	o the cause(s)
)	0 N N N N N N N N N N N N N N N N N N N	~	29b. Signature and title of certifier	Marmal			31506	290	Sept. 18,	**
			30. Name and address of person who co Anita Aggarwal, M.	D. 110 Ivory	Street		ashingtor	n, DC 20	010	
***	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2006	39. Registrar's Signatur	Jose	E.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Harris J Prager State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day Y September 21, 2006 **JEFFREY PRAGER** HARRIS 1156 hrs Medical Examine 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Randallstown **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Months Director Days Hours Min Country) 1 X M 2 07/23/1960 218**-**76-6767 46 MD Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Yes 2 X No MD BALTIMORE OWINGS MILLS must be notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 VILLAGE QUEEN DRIVE USA 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Yes Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify Specify. WHITE þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Baltimore, MD 21215-0036 **PODIATRIST** 5+ PODIATRY of Health and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **PRAGER** Be ROBERT ESTELLE GREENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is JAMIE BURCHETT / SISTER 132 STARHILL LANE - BALTIMORE, MD 21228 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BETH ISAAC ADATH ISRAEL 9/22/2006 DUNDALK, MD Donation 5 Other Specify 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Edneral Se. Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Is dase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart be cause on each line. Approximate Interval Physician Between Onset and ist only /Medical Complications of chronic drug use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED **AMENDED** item#23a,27,perME,g860, 10/11/06 TT Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Fo the Hospital or Attending Physician: Be Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: X Natural Pending Yes 2 No 2 Accident Investigation To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 22, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) strar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** DAVID ROBERTS, SR. CHARLEY RAY September 22, 2006 3:58 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours Min Yrs. 217-32-2164 Director 71 30, 1935 Tennessee Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location r than "natural", or iteme 23a or 28e-f show the Medical Examinar must be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince George's Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8208 Cypres Street 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filled within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo If Yes, Give Year or Dates: Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 8 Automobile Mechanic Automotive other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wallace David Roberts, Sr. Ella Mae Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 Is n any Injury or other treun Kevin Roberts son 7515 Patterson Court Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery 9/27/2006 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licensee Bonaldson Funeral Home, P.A. \_ / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, or c shock, or heart failure. List of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 the attending physicien be Physician/Medical The law requires that the death certificate use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ₫ Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be Chronic Respiratory Failure 1 A Yes 2 No 3 Probably 4 Unknown Completed peen Chronic Obstructive Lung Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Cor Pulmonale 2XXNo 1 ☐ Yes 1 Yes 2XXNo the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXXVo 2 KR/Outpatient 3□ DOA this After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. 28d. Describe how injury occurred Injury at Work? 5 Pending investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, rint) William A. Warren, M.D. 321 Prince George's Street Laurel, MD 20707 31. Date filed (Month, Day, Year) 5EP 2 6 2006 32. Angistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygieney 30456 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KUSNAK 1.40 1 M ANDY Mence/21 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ellicott City Health & Rehab Ctr Ellicott City Howard If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCT 21,1918 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 ☐ F Director 275-16-9018 87 Ohio Usual Residence of Decedent death with the Maryland 10b. County 10a State 10c. City, Town or Location iral', or Itams 23a or 28e-f show Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Howard Elkridge 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5831 Diggers Lane 21075 USA by Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If than 27 is marked other than any injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 22.7 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 【No 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner 9 Coal Mining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Rusnak Martha Leshondak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Ann Rusnak/wife 5831 Diggers Lane Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/22 / 06 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Cardiovaranlar Procase Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a sonsequence of): Examiner law requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and doe detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Coknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performed? Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔼 🐿 Lo Other: ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ANatural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30661 September 21 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-69 Rys Nece Read Sabapallu Pack 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

Reginald J. Rucker

6-07063 INK UNK		State of Marylan				<b>delible Ink</b> nd Mental					
		1- For State Registrar	Ce	rtificate o	f Death				006 30	14	
Physici Medical Exam		Decedent's Name (First, Middle,Last)     Reginald     Aa. Facility Name (if not institution, give street and numles)	J. R	ucker				Day Year Der 18, 2006	3. Time of Dea 1805 hrs		
		2300 block West Lanvale Avenue	per)		4b. City, Town, Baltimore	or Location of D	eath	4c. County of			
Funeral	_	5. Social Security Number 6. Sex 7	Age (In yrs	ast birthday)	If Under 1 Y	ear If Under 24	Hrs. 8. Date of B	Birth(MM/DD/YYYY)	N/A  9. Birthplace (State o	or	
Director		213-19-0295 1X M 2 F Usual Residence of Decedent	3	3 Yr		ays Hours	Min	2, 1973	Foreign CountryMary1		
wany		10a. State 10b. County	10c. City	, Town or Loca	tion				10d. Inside Cit		
Maryland 28a-f show 1 at once.	ţō	Maryland N/A			Balti				1 X Yes 2	No	
ie Mar or 28a	Director	10e. Street and Number			10f. Zip Code			10g Citizen of Wha	,		
with the 18 23a re noti	_	2649 W. Lafayette Aven		.S. 13. W		.216	( Specify Yes or N		USA American Indian, Blac		
death or iten	Funera	1 Never Married 2 Married Armed Force	es? 2 X No	lf Y	es, specify Cub	an, Mexican, Pu	erto Rican, etc.)	White,		,n,	
s after ral", c	by F	3 Widowed 4 Divorced If Yes, Give Year		1		lo specify:		Specify.	Black		
2 hour "natu	ted	15. Decedent's Education (Specify only highest grade  Elementary/Secondary (0-12) College (1-4)				ation (Give kind fe. DO <b>N</b> OT use		16b. Kind of Busin	ness/Industry		
036 ithin 7 ine r than Ledica	ompleted	12	,		Disable	ed			N/A		
15-0 filed w Hygie d othe	ပ	17. Father's Name (First, Middle, Last)			-	18 Mother's N		Maiden Surname)	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
21215-0036 wild be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be	Moses Rucker  19a. Informant's Name/Relationship (Type, Print )		19h Madin	a Address (St	act and Norther	Bertha L	assiter	State, Zip Code)21		
	٦	Darlene Rucker-Williams/S	ister	4503	Brightw	ater Ct	. Ant 1	D Owings 1	State, Zip Code)21:	117	
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumati		20a Method of Disposition	20b. i	Place of Dispos crematory or ot	sition (Name of c	emetery,	Date	20c. Location - C	ity or Town, State		
Pages Pages nent of ant: I		4 Donation 5 Other Specify Metro Crematory, Inc. 9/22/06 Baltimor									
Salt ermit. Separtr mport		21. Son tyre of Funeral Service Licensee  22. Name and Address of Facility Cremation Society of M  20. Fine device In Proceedings of M  20. Fine device In Procedure In Proc									
Physician	1	Edward A Gregorchik  23a. Part I. Enter the disease, or complications that cause	ed the death	1/~	19 Frede	TICK KO	an Kaltir	mora MIII	71.7.78		
/Medical		failure. List only one cause on each line  Immediate Cause (Final disease a Gunshot wou			no mode of dyni	g, sacri as sai aic	ac or respiratory ar	rest, shock, of flear	Between Ons  Death	set and	
Examiner		or condition resulting in death)  Due to (or as a co									
	-e	Sequentially list conditions, if any, leading to immediate bulleto (or as a co	nsequence o	f)·							
1.	Examine	cause. Enter Underlying Cause									
xecuted  n and  transit	Exa	events resulting in death) Last Due to (or as a co	nsequence of	f):							
9 E E	dical	UNPENDED		· ·				<u> </u>			
ox 68760, such certificate be ex attending physician or use as the burial.	sician/Medi	IF FEMALE: 23b. Was decedent pregnant in the						23d. Date of de	livery	_	
x 68 h certif tending use as	iciar	past 12 months?	at time of de	ath	tal death 3 her (Specify)	Ectopic pre	gnancy	Month	Day Ye.	ar	
Bo he deat the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown									
Division of Vital Records, P.O. Box 68760, no the Hospital or attending Physician: The law requires that the death certificate be within 24 hours after death Atter this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	þ	Part II. Other significant conditions contributing to de	ath but not re	esulting in the u	ınderlying cause	given in Part I.			te to the cause of dea		
rds, require been si	Completed								re autopsy findings av		
of Vital Records, ig Physician: The law require this certificate has been sineral director, page 2 should be	dmo							ormed? dea			
tal Rec	οl	to 25. Was case referred to medical 26 Place of Death (Check only one)									
hysici	To B	1 V Tes 2 INO	itient 2	ER/Outpatient		Other Nu	rsing Home 5	Residence 6	Other: Scene		
n of iding P		27. Manner of Death  1 Natural 5 Pending FOUND:	njury y,Year)	28b. Time of I	· · _ ·	ury at Work?	28d Describe Subject sho	how injury occurred			
Division tal or Attendi 15 after death al Director: A	icati	2 Accident Investigation Sep 18, 20		1755 hrs	et, factory, office	Yes 2 ✓ No	29f Location (	Stroot and Number	or Rural Route Numbe	- 01	
Divisior Hospital or Attenc 24 hours after death Funeral Director:	Certification:	Galaide	ocal Stree		n, rastery, smoo	Danaing, etc.	or Town, S	State)	venue, Baltimor		
Di To the Hospital within 24 hours a To the Funeral I completely filled		29a Certifier 1 Certifying Physician: To the best of	my knowledg	ge, death occur	red at the time, of	date and place, a	and due to the caus	se(s) and manner as	started	0, 111	
To the How within 24 h	Medical	one) 2 Medical Examiner: On the basis of e and manner state  29b. Signature and title of certifier	xamination ar d	nd/or investigat			d at the time, date				
		Queto			- 1	se number		29d. Date signed September 19	(Month, Day, Year)		
1		30. Name and address of person who completed cause o	f death (Item	23a)	_			Copiciniber	-, 2000 		
5		Ana Rubio MD. Assistant Medical Exa			treet, Baltim	ore, MD 212	01				
St Regist	tate 31. Date filed (Month, Day, Year) 33 Registrar's Signature										
Regist	TKU	SEP 2 6 2006 January St. Special									

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of Man	land / Depa <i>Cei</i>	artment of H	ealth and Death		giene Reg. No. 2	106	30458
9	Physic /Medi		1. Decedent's Name (First, Middle, Last,	)	R	oucha	vd	2. Date of De Month	path Day	Year OOG	3. Time of Death
*	Examir		4a. Facility Name (If not institution, give VA Nursing Center	,		4b. City, Town, or Baltimon	re		4c. County	of Death	
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Funeral Director		5. Social Security Number 6. Security S	x	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		ıy, Year)	Count	lace (State or Foreign try) yland
	th the Marylan or 28a-f ehow e notified at	Director	MD         Baltimor           10e. Street and Number		C. City, Town or Lo				10g. Citizen of \		0d. Inside City Limits 1 ☐ Yes 2 ☐ No X
9036	be filed within 72 hours after death with the Maryland tial Hygiene.  Id other than "natural", or Iteme 23e or 28e-f ehow event, the Mydical Examinations in a profiled and event, the Mydical Examinations.	by Funeral	3 Hathaway Rd.  11. Marital Status  1 Never Married 2 Married  X Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 46	1	Timor Was Decedent of Hi f Yes, specify Cubar □ Yes 2☑ No		Specify Yes or No to Rican, etc.)		ce - America ck, White, e	etc.
Maryland 21215-0036	filed within 72 h Hygiene. Nher then "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 10	cation e completed) College (1-4or 5+) N/A	(Give	lent's Usual Occupa kind of work done o DO NOT use retired,	luring most of wo		16b. Kind of Bi	Fabri	
yland	2 should be fill and Mental H is marked ott aumatic even	To Be	17. Father's Name (First, Middle, Last)  Jean L. Rouchard					me (First, Middle, a M. And		10)	
	りもにき		19a. Informant's Name/Relationship (Ty  Charles F. Kemp/so	n-in-law	5205	g Address (Street a Linton F					Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo- cemetery, cren Metro Cre	natory or other place	_	t. 25,	20c. Location -		
Balt	permit. Departr Importe any init		21. Signature of Funeral Searce License  23a. Part1. Enter the disease, or complishock, or heart failure. List only or		1 00		s of Facility				
	Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, a complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)		nsequence of):				rrest,		Approximate Interval Between Onset and Death
( 68760,	death certificate be executed e attending physician and id for use as the buriat-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as a co	insequence of):						
P.O. Box	y th	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of deliver nth E	ry Day Year
	The law requires that ste has been signed b page 2 should be deta	Ď	Part II. Other significant conditions con	tributing to death but no	ot resulting in the un	derlying cause give	n in Part I.				e cause of death?
al Rec		Completed							rmed?	prior to com death?	sy findings available inpletion of cause of
Division of Vital Records,	Phys this ral dii	ıtlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 🗹 Nursing F	ath Check only o			ŀ
Divisi	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, streepecify)	eet, factory, office		28f. Location (S City or Tox	Street and Number vn, State)	er or Rural	Route Number.
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of mer: On the basis of exa	y knowledge, death imination and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	o, and due to the dirred at the time, d	cause(s) and ma date and place, a	nner as sta and due to t	ited. the cause(s)
	To the Complei	₹ .	29b. Signature and title of certifier	ice M	. 0	29c. License	number 77809		29d. Date signed		12006
	H'		30. Nam and addr ss of person who co Andrew Mrowie	-790	2 1-016	N-2 Wes-	Blud	Balt			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2	32. Reprirar's 3	Signature	fores					

State of Maryland / Department of Health and Mental Hygiene 2006 30459 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death SEPT. Physician  $2^{\frac{Day}{2}}, 200^{\frac{Y_{gar}}{6}}$ FRANCES ROSE RUPINSKI 8:10 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8231 ACADEMY ROAD ELLICOTT CITY HOWARD 8. Date of Birth (Month, Day, Year)
FEB. 4,1923 MARYLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X Months Days Hours 215-12-7395 Yrs. Director 83 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f ehow 27 le marked other then "naturel", or Iteme 23a or 28a-f ehov traumatic event, the Mudical Exemple regal be notified at 1 ☐ Yes 2 No Director HOWARD MD. ELLICOTT CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8231 ACADEMY ROAD 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: 3 XWidowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within 7 t of Health and Mental Hygiene. If item 27 le marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH BINKOWSKI AGATHA MAJKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY RUPINSKI/ DAUGHTER 8231 ACADEMY ROAD, ELLICOTT CITY, MD. 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If itel eny injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 9/27/06 BALTIMORE, MD. 21. Signature of Fun. Liverice Licensee 22 Name and Ac LILLY & 700 S. Name and Address of Facility
LLLY & ZEILER INC. FUNERAL HOME 21224
00 S. CONKLING STREET, BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** evkenna Imautus /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any localing to initial adults cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dira to for as a nonsecuence of: Examiner burial-transit be executed Due to (or as a consequence of): Box 68760 attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No ò Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA his funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after de Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier icai Certifying riffsteam: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 808 UnClin 31. Date filed (Month, Day, Year) SEP 2 6 32 Registrar's Signature 2006 Registrar

			1 - For State Registrar	e of Maryland /	-	rtment of H		_	giene Reg. No	006	30460
	Physici	an	Decedent's Name (First, Middle, Last)     SHIRLEY	М	DOC	= N		2. Date of De	ath Day	Year	3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give, street ar	M.	ROS	4b. City, Town, or	Location of Deal	Septembe	-	2006 County of Death	8.30 PM
			dinai Hospital of	Baltimon	_	130	none				N/A
	Funeral Director		5. Social Security Number 6. Sex 0 1 M 2 N	7. Age (In yrs. last bi	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da 02/16/	1928	9. Birthpl Coun	ace (State or Foreign try) MD
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	wn or Lo	cation				10	Od. Inside City Limits
	e Mary Se-f sh tiffed	ctor	MD BALTIMORE	В	BALT	IMORE					1 ☐ Yes 2 No
	with the	Director	9 POMONA WEST, APT. 4			10f. Zip Code	208		10g. Citize	on of What Coun	try? USA
	ems 23	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. ad Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba		Specify Yes or No	- 14	I. Race - America	an Indian,
36	filed within 72 hours after death with the Maryland Hygiene. Vither then "natural", or Items 23a or 28e-1 show ent. I'te Mcdical Examinating the notified at	by Fu	1 Never Married 2 Married 1 If Ye	Yes 2 X No s, Give or Dates:	1	☐ Yes 2 X No	Specify:	to modif, etc.,	1	Black, White, e	WHITE
5-0036	72 hou 'natura	eted	15. Decedent's Education (Specify only highest grade comple	16a	(Give	ent's Usual Occupa	lurina most of wa	rkina	16b. Kind	f of Business/Ind	ustry
121	I within iene. r than	Completed	Elementary/Secondary (0-12) Colle	oge (1-4or 5+)	life. L	OO NOT use retired MAKER	)		OWN	HOME	
חם	0 = 0 =	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		umame)	
Maryland		၉	MICHAEL  19a. Informant's Name/Relationship (Type, Print		OHEI	g Address (Street a	HILDA	ural Route Numbe			Code)
_	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		RONALD ROSEN / HUSBAN	D 9	POI	MONA WEST					
altimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal	from State cemete	ry, cren	ition (Name of latory or other place		Date (2006		Ation - City or Tov	
altil	permit. Pages Department of I Important: If it any injury or o		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	DEIN C		MORIAL P		)L LEVIN:		DALLSTON BROS	
n	88168		Jay Cler Lei	had a sound that doort . Do	8	000 REIST	ERSTOWN	ROAD - I	PIKES		4D 21208
	Physician		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	on each line.	not ente	r the mode of dying	g, such as cardia	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	e to (or as a consequence	of):	OUM.					
	ZAGIIIII (C)	er	Sequentially list conditions, if any, leading to immediate	e or as a consequence	of):	37 V					
	ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Judentying Cause (Disease or injury that initiated events resulting in death) Last	espiratory	Fo	eluse					
8/60,	cate be executed physician and i the burial-transit	dlcal E	d d	e to for as a consequence	OI):						
٥	certificate be executed Iding physician and Ise as the burial-transit	0	IF FEMALE:								
0	atter for u	Physiclan/M	23b. Was decedent pregnant 1 1 1 1	s, outcome of pregnancy live birth 2  Petal death Pregnant at time of death		Ectopic pregnancy Other (specify)			23	d. Date of deliver Month	y Day Year
	the oy the	Physi	9 Unknown	Jnknown							
ords,	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing Aovitu Value	to death but not resulting i	in the un	derlying cause give	n in Part I.		bacco use es 2 🗆		e cause of death?
I Records	The law ate has b page 2 si	Completed	Coronary Arto	iy disea	20			24a. Was autop perior 1 \( \to \text{ Yes} \)	an sy med? 2 <b>X</b> No	24b. Were autop prior to com death? 1 \( \subseteq \text{Yes} \) 2	sy findings available pletion of cause of
VItal	Physician: this certific ral director,	o Be (	25. Was case referred to medical examiner?	- Au		3CI DOA Othe		ath (Check only o			
10 [	ding Phyen.  After this funeral di	-	27. Manner of Death 28a. I		utpatient Time of Injury	3 DOA 28c. Injury Work	at	lome 5 Resid			
JIVISION	Attending or death. actor: After by the fune	icatlo	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home, fa		M 1 🗆 Y	es 2□No	29f Logation /6	troot and I	Mumbarar	Doub Musha
2	tal or A s after al Dirac ed in by	Certification:	4 Homicide determined	ouilding, etc. (Specify)	ami, sue	er, ractory, office		City or Tow	n, State)	Number or Rural	noute Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Physician: T 2 Medical Examiner: On and	o the best of my knowledge he basis of examination an manner stated.	e, death	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the or rred at the time, o	ause(s) ar late and pl	nd manner as sta ace, and due to t	ted. the cause(s)
	within To th	×	29b. Signature and title of certifier	. D		29c. License	0022-		0 .	signed (Month, D	
	10		30. Name and address of person who completed	cause of death (Item 23a)	(Type_F	rint) A			septer	n ber 20,	2006 nove MD 2121
	10		AMANDEED SINGH	Inai Pospt	tal	of Battern	ore, 240/	W. Belve	lereA	ve Baltin	more MD 2121
:	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A.	SALE P				,	

			1 - For State Registrar	State of Ma	aryland /	Certifica	ent of H ate of L	Death		giene2 (	106	30461	
	Physici	an	1. Decedent's Name (First, Middle, Last	)					2. Date of De Month	Day	Year 2006	3. Time of Death	
	/Medic	al	Fred Earl Rand  4a, Facility Name (If not institution, give	street and number)		4b. C	ity, Town, or	Location of Dea	septen		by of Death	3,30 n.M.	-
	Exami	ei	Baltimore Washing	atron Marl	in/Con	tr GI	en An	rnie.			Arur	ndel	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last b	oirthday) If Un Month	der 1 Year ns Days	If Under 24 Hrs Hours Min		th		lace (State or Foreign	
	Director		431-30-6311 Usual Residence of Decedent		81	115.			01/1/	/1925	<u> </u>	AK	_
	ryland how		10a. State 10b. County		10c. City, To	wn or Location					1/	0d. Inside City Limits	_
	8a-f	cto	MD Anne Ar	unde1	Pas	adena						1 ☐ Yes 2 No	
	with ti		10e. Street and Number	a			Zip Code	2		10g. Citizen of U.S.A		try?	
	death ms 23	Funeral Director	184 Meadow Roa  11. Marital Status	12. Was Decedent E		13. Was De	21122 cedent of Hi		Specify Yes or No rto Rican, etc.)	- 14. Ra	ce - Americ		-
98	or its		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give		-	specify Cuba s 2 <b>⊠</b> No		no Hican, etc.)	Speci	ack, White, e		
Ö	ilied within 72 hours after death with the Maryland Hygiene. uther then "natural", or items 23a or 28s-f show with the Medical Examinat must be multified at	ed by	3 X Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	1946					16b. Kind of E	W.I.I.	ite	_
215	hin 72 a. an "na	Completed	(Specify only highest grad	le completed) College (1-4or 5-	+1	(Give kind of life. DO NO	work done of Tuse retired	ation during most of wo )	orking	Feder		lu a try	
2	ygiene ygiene yer the	Соп	7			Carpen	ter			Gover		t	_
Maryland 21215-0036	ntal H	9 Be	17. Father's Name (First, Middle, Last)  John Dewey Ran	a					me <i>(Fir</i> st, <i>Middl</i> e, e Fern		me)		
JZ.	should nd Men marke umatic	2	19a. Informant's Name/Relationship (7)		19	b. Mailing Addr	ess (Street a		ural Route Numbe		, State, Zip	Code)	_
	and 2 Balth a n 27 Is		Tim Rand / Son					Road,	Pasade	na, MD	211	22	
Baltimore,	iter		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place cemet	of Disposition (I ery, crematory of	Name of or other place	θ)	Date	20c. Location	- City or To	wn, State	_
<u>=</u>	permit. Page Department of Important: If any injury or once.		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		Glen				/21/06				_
Ba	Depa impo any i		21. Signature of uneral service Econs						ive, Pa			Home, PA 21122	
			23a. Part1. Enjer the disease, or compl shock, or heart failure. List only o	ications that caused ne cause on each lin	the death. Do							Approximate Interval Between	_
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a Chmoni	c obs	motin	re y	sulmon.	my 0	isers	2	Onset and Death	
	/Medical Examiner		resulting in dealiny	Due to (or as a	a consequence	ə'of):	,		/				
	3	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a	consequence	e of):							_
	ecuted ind	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
68760,	be ex sicien s burial	al E)	Tossining in county cast	Due to (or as a	a consequence	e of):							
687	intificate be executed ing physicien and K	edlcai		J									_
Вох	th cert tendin r use	an/M	230. Was decedent pregnant	23c. If yes, outcome o		th 3⊟Ectopic	pregnancy				ate of delive	•	
О. Ш	The law requires that the death cer ete has been signed by the attendir page 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t 9□Unknown		5 Cther				M	onth	Day Year	
α,	that the	by Ph	Part II. Other significant conditions co	ntributing to death bu	it not resulting	in the underlyin	g cause give	en in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?	_
rds	w requires been sign should be	ed b							×	∕es 2□No	3 🗆 Proba	ably 4 □Unknown	
Vital Records,	iaw requ	Completed							24a. Was	osv	prior to con	sy findings available	
a E	ician: The certificate I ector, pag								perfo 1 ☐ Yes	rmed? 200 No	death?	2□ No	
	/sicla. s certii	To Be	25. Was case referred to medical examiner?	Hospital: Inpatier	nt 2□EB/C	Outpatient 3	DOA Othe	ar-	ath <i>Check only o</i> Home 5 ☐ Resid		has /Caash		
Division of	Attending Physician: r death. sctor: After this certific by the funeral director, i		27. Manner of Death 1 DNatural 5 □ Pending	28a. Cate of Injury (Month, Day	y 28b.	Time of Injury	28c. Injury Work	at		now injury occur		/	-
Sio	ttendii Jeath. Ior: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be	99 - Di ( l-)		М		res 2 □No	201				
Σ	after after I Direct	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	. (Specify)	rarm, street, fact	tory, office		28f. Location (S City or Tox	vn, State)	ber or Hural	Houfe Number,	
	To the Hospital or Attending Physician: The lav within 24 Junus after death.  To the Funeral Director: After this certificate has cumpletely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  Certifying Phy Description on the control of the control of the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifying Phy Description on the certifier o	sician: To the best o ner: On the basis of and manner stat	examination a	ge, death occurr and/or investigati	ed at the timi ion, in my op	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)	_
	To the	₩ W	29b. Signature and title of certifier				29c. License	number		29d. Date signe	ed (Month, L	Day, Year)	_
1		-	Again	Ms	<u>J</u> .		1)4	-3977	7 5	estem	ser	18 2006	
	HT		30. Name and address of person who co	mpleted cause of de	ath (Item 23a	(Type, Print)	ē.	lia R	um a	04.4	7:-1	18 2006	
	∾. Sta	te	31. Date filed (Month, Day, Year)	. Registra	r's Signature	, , , , ,	14	un	minu.	IND	400	21	-
4	Registr	ar	SEP 2 6 2006	Eleva	B	Soule							

			For State Registrar	State of Ma	arylan	-	artment of I <i>rtificate of</i>	Health and N <i>Death</i>	Mental Hy	giene Reg. No	ZIIIIb	30462
			Decedent's Name (First, Middle)	Last)					2. Date of De			3. Time of Death
	Physici /Medic		David Alle	n Singleton					Septemb	per 2	25 <b>,</b> 2006	
	Examin		4a. Facility Name (If not institution,					or Location of Death		4c.	. County of Death	
	Franci		Upper Chesapeak 5. Social Security Number	e <u>Medical Ce</u> 6. Sex 7. Ag	enter	last birthday)	Bel If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	Harford 9. Birth	nplace (State or Foreign
(4	Funeral Director		218-40-1532	1XM 2□F		64 Yrs.	Months Days	Hours Min.	Dec 22	$\frac{2}{2}, \frac{Y_{\theta ar}}{1}$	941 Ma	ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation			-		10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f ehow	tor	Maryland Harf	ord		Bel	Air					1 ☐ Yes 2 📆 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	untry?
2	ath w	rail	2306 Creswell R			2 10		.015			USA	
330	ours after dea rai', or items	by Funeral	11. Marital Status  1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 X I If Yes, Give Year or Dates:	Ever in U. No	.5. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Decity Yes or No Dican, etc.)	0.	14. Race - Amer Black, White Specify: Wh	e, etc.
(A) B	72 hc	etec	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Dece (Give	dent's Usual Occu kind of work done	pation during most of worked)	king	16b. K	(ind of Business/I	ndustry
0 12	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		enance M				hemical	Industry
9	2 should be filed with and Mental Hygiene is marked other tha aumatic avent, Ital	0	17. Father's Name (First, Middle, L	_ast)				18. Mother's Nam	ne (First, Middle			riado ery
lan Jan	should be and Mental is marked of aumatic ave	To B	George Single	eton				Grace	Mae Fou	ınds		
a O E	2 sho and }	ľ	19a. Informant's Name/Relationsh					t and Number or Ru				
() ()	1 and Health em 27 ther to		Betty J. Sin le	ton, Wite	20b. F		Creswell osition (Name of matory or other pla	Road Bel	Air, M		and 210: ocation - City or	
9 25 06 altimore, Maryland	Pages nent of I nt: If it		1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State	1			Inc. 09/2	6/06			Maryland
Balti	pernit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic av <u>once</u> .		21. Signature of Funeral Service I	Lugar	·			ess of Facility Society rick Road		land	l, Inc.	nd 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the deat	h. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory a	arrest,	rary ra	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition									Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	1.1	10.2	Λ\-			
	ZAGIIIII.	er	Sequentially list conditions,	b. Seven Due to (or as	a conseq	nom C uence of):	Obs tru	ctive Lun	9 Disea	ase	•	10 yrs .
/	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,						
100	ficate be executed physicien and is the burial-transit	I Exa	resulting in death) Last	Due to (or as	a conseq	uence of):						
<b></b>	icate b physic s the b	edical		d								
0. Box 6	e death certi the attending ned for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	⊒Ectopic pregnand ⊒ Other (specify) _	су			23d. Date of deli Month	very Day Year
B, P		ρ	Part II. Other significant condition  Hyperient	_	ut not res	ulting in the i	underlying cause g	even in Part I.		1		the cause of death?
Recor	ician: The law requires certificete has been sign rector, page 2 should be	Completed							24a. Was auto perfi	ormed?	prior to death?	topsy findings available completion of cause of
	ysician: is certifice director, p	BeC	25. Was case referred to medical examiner?					26. Place of Dea		-		
of S	2 v :5	မ	1 XYes 2 No	Hospital: 1 ☐ Inpatie	- 1		nt 3LI DOA				6 □Other (Spec	cify)
40	ding Phy h. Alter thi funeral o	tlon:	27. Manner of Death  1 Natural 5 □ Pending investig		y Year)	28b. Time o Injury	Wo	uryat ork? ]Yes 2 ∐No	28d. Describe	now inju	iry occurred	
Singleta	To the Hospitel or Attendiwithin 24 hours attended To the Tenerel Director: A completely filled in by the formal parts of the	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be One Place of In	ury - At h	ome, farm, si	reet, factory, office		28f. Location City or To	(Street al	nd Number or Ru e)	ral Route Number,
	Hospitel 24 hours : Funerei stely filled	Medical C	29a. Certifier  (Check only one)	g Physician: To the best Examiner: On the basis of and manner st	f examina	wledge, dea ition and/or i	th occurred at the to	ime, date and place opinion, death occu	, and due to the rred at the time	cause(s , date an	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	- (-/			29c. Licen	se number		29d. Da	ate signed (Monti	n, Day, Year)
	- > - 0		140	two	>		Do	018424	-	Sep	1+. 25	2006
-	Y		30. Name and address of perspans	MD. 1908	At	wfore	Rd,	Fallston	My	21	047.	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 6	2006 32 Registr	rar's Signa	tyr A	certi					

			For	te of Maryland	i / Depa	artment	of He	ealth a		-	ene	0.0	201.63
		_	State Registrar		Cei	rtificate	of L	Death			g. No	06	30463
	Physicia		1. Decedent's Name (First, Middle, Last)  Albert Spokes							2. Date of Death Month September	Day	Year 2006	3. Time of Death  2:30PM
1	/Medic	al	4a. Facility Name (If not institution, give street a	nd number)		4b. City. T	Fown, or	Location o		septemb	1	y of Death	2:501
4	Examin	eı	5610 Chamblis Drive	na namos,				ville				Howard	i
	Funeral		5. Social Security Number 6. Sex 1.77, 01, 601,6 1 1 1 M 2	7. Age (In yrs. la	st birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpi Coun	lace (State or Foreign
3	Director	l L	1//-01-0010	91	Yrs.					MAY 3,	1915	Penn	sylvania
	and and	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	Mary First	ţō	Maryland Howard			(	Clar	ksvi1	1e				1 □ Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip	Code			10	g. Citizen of	What Coun	itry?
	23a (23a)		5610 Chamblis Drive					1029				USA	1 8
	er de litems	Funeral	Am	s Decedent Ever in U.S ned Forces? ]Yes 2[XNo	S.   13. '	Was Deced If Yes, spec	ent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		ice - Americ ack, White,	
336	irs aft	5	If Y	es, Give		1 ☐ Yes 2	2[XNo	Specify:			Speci	ty: Wł	nite
9	I within 72 hours after death with the Maryland ilene. Iden. It than Instural, or Items 23e or 28e-f show I're Medical Exalt in et must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Dece	dent's Usua kind of wor	I Оссира	ition urina mosi	t of workir	ng	16b. Kind of	Business/Inc	dustry
2	within 7 ene. than "	mple	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	life.	DO NOT us	e retired)	)			TT		
12	be filed w tal Hygie d other ti		12 17. Father's Name (First, Middle, Last)		Hors	e Farr	n Ope			(First, Middle, M		e Farn	1
and	Q 20 0	To Be	Harry Spokes						Su	sanna Ro	oach		
Maryland 21215-0036	should and Men is marke	-	19a. Informant's Name/Relationship (Type, Pri	nt)	19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	l Route Number	City or Town	n, State, Zip	Code)
	t and 2 shou Health and M tem 27 is mar other traumat		Virginia H. Spokes/							Clarksv			
Baltimore,	0 ± 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	Trom State	ace of Dispo						20c. Location		
Ħ.	permit. Pag Department Important: any injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Meti	ro Cre						Balti		MD, Inc.
Ba	permit. Departm Imports any inju		2 lund thick	مام ا						Baltimo			
			Edward A Gresore  23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused the death.	. Do not en	ter the mode	e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Suba	cute	Ba	rill	Ma	l Es	ndoce	ende	w	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ									
*	- Adminion	-	Sequentially list conditions, b	Oue to (or as a consequ	ence of):	-							
	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Cong	estu	ul	he	all	Ac	ulur	2		
o,	ate be executed hysician and the burial-transit			oue to (or as a consequ	ence of): 🕝				U				
8760,	ate be hysici the bu	licai	d	Sep	w								
x 68	eath certificate attending phy I for use as the	Physician/Med	IF FEMALE: 23c. If y	es, outcome of pregnar	nev						23d F	ate of delive	arv
Box	leath of attended for u	cian	in the past 12 months?	Live birth 2 Fetal Pregnant at time of de	death 3	□Ectopic pr □ Other (sp						fonth	Day Year
P.O.	that the ded by the detached	hys	9 Unknown 9E	Unknown						T			
	res tha	by P	Part II. Other significant conditions contributi	ng to death but not resu	ulting in the u	underlying c	ause give	en in Part I	l.	23e. Did tol	-		he cause of death?
ord	w require been si should I	eted											
Records,	e law has b je 2 si	Completed								24a. Was a autops perfori	y	prior to co death?	opsy findings available impletion of cause of
a	sician: The law certificete has b irector, page 2 s	e Co	25. Was case referred to medical					26 Place	of Death	1 Yes	S 115/5	1 ☐ Yes	2 No
<u>S</u>	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 No Hospita	it: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3 DC	OA Cthe			me 5 Reside		ther (Specif	(y)
0 0	ng Ph tter th neral		27. Manner of Death  1 Anatural 5 Pending	n. Date of Injury (Month, Day Year)	28b. Time of	of 2	28c. Injun Worl	y at k?		28d. Describe h			
sio	tendii leath. tor: A the fu	cati	2 Accident investigation	Olean of Injury At he	= 0 form of	M		Yes 2□		29f Location (S	treet and Nur	nher or Rus	al Route Number,
Division of Vital	after of Direc	Certification:	4 Homicide determined	<ul> <li>Place of Injury - At ho building, etc. (Specify</li> </ul>		ген, таскогу	y, omce		1	City or Town		ibai oi ribie	ii riodie rumbei,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending physician and and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		29a. Certifier 1 Certifying Physician										
	the Ho in 24 the Fu	Medical		nd manner stated.									
	Viting To To To	2	29b. Signature and little of certifier	en		290	) [	o number	70	3	enten	led (Month,	)13F2006
	1 m		30. Name and address of person who complete	ed cause of death (Item	23a) (Type	Print)	11	nn N	) 0	1090	(1)	7111	Antomas
	20		29b. Signature and little of certifier  30. Name and address of person who completed to the complete state of	lane C	Com	licul	u	עוט	01	049	34	curi j	(In maril
		ate	31. Date filed (Month, Day, Year)	39 Registrar's Signal	ture	and s							
1	Regist	rar	SEP 2 6 2006	Eller Di	1								

h

SEEBURGER, BETTY

			For State Registrar		State of M	aryland	i / Depa <i>Cei</i>	artment of F rtificate of	lealth <i>Deatl</i>	and M h		giene Reg. No		06	3046	L
	D		1. Decedent's Name (First	Middle, Las	t)						2. Date of De Month	ath Da	ıv Y	/ear	3. Time of Death	
	Physicia /Medic		Betty Ju	ine S	eeburger						SEPT	2	1 2	006	4:00 A M	1
1	Examin		4a. Facility Name (If not in	_				4b. City, Town, o				40	. County of			
			ST AUNE		OSPITAL		of highday)	BAL If Under 1 Year		or 24 Hrs.	8. Date of Bir	th	N/		lace (State or Foreigi	_
	Funeral Director		5. Social Security Number 219-10-7110 Usual Residence of December 1		□M 2[X[F	ge (In yrs. Ia 80	Yrs.	Months Days	Hours		8. Date of Bir (Month, Da OCT 10	Year 1	925	Coun	MD	
	land ow	1		County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits	
	Mary a-f sh	ò	MD Ba	altimo:	re	Cato	nsvi1	le							1 ☐ Yes 2 ☐ No	)
	or 284	Director	10e. Street and Number		II ' . m1			10f. Zip Code				_	tizen of Wh	at Coun	itry?	
	s 23a	rai	5741 Edmonds	son Av		From in U.S.	10.1	21228	diamenia C	Veining (Co.	oifu Voc or No	US	5A 14. Race -	Amorio	an Indian	
Maryland 21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examinant he notified at	by Funeral	11. Marital Status  1 Never Married 2  3 Widowed 4 D		12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates:	?		Was Decedent of H If Yes, specify Cubin 1 1 Yes 2 No			Rican, etc.)			White,	etc.	
Ö	72 ho	ted	15. D	ecedent's Ed	lucation de completed)		16a. Dece	dent's Usual Occup	oation	nst of worki	na	16b. F	Kind of Busi	iness/Ind	dustry	
21	S - 2	Completed	Elementa Secondary		College (1-4or	5+)		kind of work done DO NOT use retired	d)	30. 07 110717	9	_	TT			
21							Home	maker	10 Mai	horla Name	(First, Middle		vn Hon			_
and	og la b ≥	Be	17. Father's Name (First,								•		,	,		
Ž	d 2 should by	은	Warner Rus				19b. Mailir	ng Address (Street			atilda U Route Numb			tate, Zip	Code)	_
	har har re		M. Charlene			r		Hilton A								
ē,	~ I 9 5		20a. Method of Disposition	1		20b. Pla	ace of Dispo	sition (Name of matory or other pla			ate		ocation - C		wn, State	_
9	Pages nent of int: if it		1 ☐ Burial 2√2 Crer 4 ☐ Donation 5 ☐ C			•	•	ematory,		9/22	2/06	Pal	timor	o 1	MD	
altimore,	permit. Pag Depertment Importent: I eny injury o		21. Signature of Funeral S	Service Licen	See C. Tod	d Drin	ıg 👸	2. Name and Address Rockabb Fu	ess of Fac	Hon	ne. P.A		balding a	,		
8	89 = 29		1	1.11				01 Frede	rick	Rd Ca	tonsvi	110.	MD 2	122		
			23a. Part1. Enter the dise shock, or heart failu	ease, or comp e. List only	plications that cause one cause on each	d the death. line.	Do not ent	er the mode of dyir	ng, such a	as cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	a	Pneu.		ia							7 days	
1	/Medical Examiner		rosulting in doutily		Due to (or a	s a conseque	ence of):									
		er	Sequentially list condition	s.	b. Due to (or a	s isonsague	ental of									_
	ansit tised	Examiner	Sequentially list condition any, leading of in rediction cause. Enter Underlying Cause (Disease or injury that initiated events	~												
o,	en an	Exa	resulting in death) Last		Due to (or a	s a conseque	ence of):									
68760,	ifficete be executed g physicien and as the burial-transit	edical			d											
	artifice ing pt		IF FEMALE:						_							_
P.O. Box	Physician: The law requires thet the death certifi this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3[	Ectopic pregnanc Other (specify)	У				23d. Date Monti		nry Day Year	
	thet	by Pr	Part II. Other significant							t I.	23e. Did t	obacco	use contrib	oute to th	ne cause of death?	
rds	w requires in been significations should be	g pa	Atric	u ti	brillation	m,	(04	rgestive			10	Yes 2	2No 3	Prob	ably 4 Unknown	n
of Vital Records,	The law re te has bee age 2 sho	Completed	heart		re, H								al de	ath?	psy findings available appletion of cause of	θ
ital	ysician: The is certificate hadirector, page	BeC	25. Was case referred to examiner?	medical					26. Pla	ce of Death	(Check only					
> =	hysic this ce al direc	To	1 Yes 2 No		Hospital: 1: Inpat		R/Outpatier	11 3 DOA		1000	me 5□Resi				y)	
			27. Manner of Death 1 ☑ Natural 5 ☐	Pending	28a. Date of In (Month, D	ay Year)	28b. Time o Injury	Wo			28d. Describe	how inju	ry occurred	d		
isio	for:	icat	2 Accident 3 Suicide 6	investigation Could not b	9 Ogo Place of Is	niunz - At hor	mo farm et	M 1 [	Yes 2		28f Location /	Stroot a	nd Number	or Rura	l Route Number,	_
Division	or Attendent efter deatl Director:	Certification:	4 Homicide	determined		tc. (Specify)		leet, lactory, office			City or To			Or Flura	rriodio radilidor,	
	To the Hospitel or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 0 (Check only 2 1 M	ertifying Ph ledical Exer	ysician: To the bes niner: On the basis and manner s	of examinati	vledge, deat ion and/or in	h occurred at the ti vestigation, in my o	ime, date opinion, d	and place, eath occurr	and due to the ed at the time,	cause(s	s) and manr nd place, an	ner as st	ated. the cause(s)	
	To the Within To the comple	Me	29b. Signature and title of			0		29c. Licens		r		29d. Da	ate signed	(Month,	Day, Year)	
	~		mara	Carmel	in 11. No	sales		P180	614			SEPT	, 2	١,	2006	
	,7	197	30. Name and address of				23a) (Type,	Print)			- 4					
-			MARIA		ELA ROS	ALES	, 5	TAGN	6-8	Itos	PITAL		<del></del>			
У.	Sta Registi		31. Date filed (Month, Da		32 Regis	trar's Signat	ure A	ulis								
	negisti	-uı	SEP %	6200	IU KURSUM	المام ال	1974									

			1 - State Registrar	Hecets Many 2	<b>708<sup>egartm</sup></b> Certific	ent of H cate of I	lealth and Me Death	ental Hygi Re	iene g. <b>12</b> 0 0 6	30465
	Physici		1. Decedent's Name (First, Middle, Last) $GUSSIELEE$	5107	7			2. Date of Death Month FPTEM	Day Yea	3. Time of Death
	/Medic Examir Funeral	ier	4a. Facility Name (If not institution, give street  \( \hat{OOD}  \text{SAMAR} \)  5. Social Security Number  6. Sex	and number)	17AL 4b. (	BA L	Location of Death		4c. County of De	eath  Sirthplace (State or Foreign Country)
	Director		246-22-8489 1□ M :	X□ F 86	Yrs. Mon	ths Days	Hours Min.	(Month, D <b>1</b> ) 19/28/ <del>2(</del>		uth Carolina_
	nyland how		10a. State 10b. County	10c. City	y, Town or Location					10d. Inside City Limits
	the Ma 28a-fa	Directo	Maryland  10e. Street and Number	Ва	altimore	. Zip Code		10	g. Citîzen of What	1 ∑Yes 2 □ No
	h with 3a or		1528 Winford Road		101	212	39		J.S.A.	Country
920	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ahow diral Examinar must be notified at	by Funeral	1 Never Married 2 Married 1	/as Decedent Ever in U. rmed Forces? □ Yes 2 ሺ No Yes, Give ear or Dates:		ecedent of H specify Cuba es 2 X No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:			•
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) C 12	opleted) college (1-4or 5+)	16a. Decedent's (Give kind c life. DO NO	of work done of OT use retired	during most of working	9	Medical	ss/industry
nd 2	be filed tal Hygie d other avant, II	Be	17. Father's Name (First, Middle, Last)		nursin	s AIU	18. Mother's Name (		faiden Surname)	
ıryla	should nd Mer marks matic	2	Gussie Rouse  19a. Informant's Name/Relationship (Type, P	rint)	19b. Mailing Add	ress (Street	Lucille J		City or Town. State	. Zip Code)
	12 ha 7		Jessie Dyer / Daught	er	1443 Win	nston A	Av <b>e</b> n <b>ue,</b> Ba	ltimore	, Marylan	d 21239
Baltimore,	of of		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Remov	arnom State	Place of Disposition emetery, crematory			WO	20c. Location - City	
altin	permit. Pag Department Important: any injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Six sture of Funeral Service License</li></ul>	Kin	ng Mem. Pa		ne. 1997297 ss of Facility The	<del>2006</del> B Derrick	altimore, C. Jones	Maryland F/H, P.A.
ä	permi Depa Impo any ir		Mule	<i></i>	4611	Park I	Hgts. Ave.	, Balti	more, Mar	yland 21215
	Fnysician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cal immediate Cause (Final disease or condition resulting in death)	I'GHT J	AN		g, such as cardiac or $I' \cup A \cap A \cap$		st,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions, b	Due to (or as a consequ	uence ot):					
68760,	ificate be executed physician and as the burial-transit	cai Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
.O. Box	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	Physician/Medical	in the past 12 months?	yes, outcome of pregna □Live birth 2 □ Fetal □ Pregnant at time of de □ Unknown	I death 3 Ector	oic pregnancy r (specify)			23d. Date of o	lelivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contribu	ting to death but not rest	ulting in the underly	ing cause give	en in Part I.			to the cause of death?  Probably 4 Wunknown
of Vital Records,	The ate h page	Completed						24a. Was an autopsy perform	prior t death No 1 □ Y	
Vit	S 5	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospit	al: 1 npatient 2	ER/Outpatient 3	DOA Othe	26. Place of Death ( er: 4 ☐ Nursing Home		i) nce 6 ∐Other <i>(Si</i>	pecify)
	anding Physath. or: After thi	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at 28		w injury occurred	
Division	Hospital or Attanding 24 hours after death. Funaral Diractor: After tely filled in by the fune	Certification:	4 Homicide	<ul> <li>e. Place of Injury - At he building, etc. (Specify)</li> </ul>	y)			City or Town,	State)	Rural Route Number,
	a Hospital o 24 hours at a Funaral D letely filled i	edical	29a. Certifier Certifying Physicier (Check only one) 2 Medicel Exeminer:	On the basis of examina	tion and/or investiga	ation, in my or	pinion, death occurred	at the time, da	te and place, and d	ue to the cause(s)
)	To the Hosi within 24 ho To the Funt completely f	Me	29b. Signature and title of certifier  Marsha  30. Name and address of person who comple  MANISHA BAHL, M  31. Date filed (Month, Day, Year)  SEP 2 6 2006	ahl, n	15	29c. License	e number 0 5 8 9 1 -	3 SE	d. Date signed (Mo	nth, Day, Year) En 25
			30. Name and address of person who comple	ted cause of death (Item	1 23a) (Type, Print)	560	( LOCA	1 RAL	IEN BO	WLEVARD 1220
0	Sta Regist	ite rar	31. Date filed (Month, Day, Year) SEP 2 6 2006	32 Registrar's Signa	J. 1994	y s	RE ; IVII	100		1659

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIPM#/&8. perFH. 6559, 9726/06, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No.2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RTHUR Day **Physician** 7:10 A.M SEPTEMBER 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOMEWOOD N. GENES15 TIMORE If Under 1 Year If Under 24 Hrs. B. Date of Birth 13-15-1914. Birthplace (State or Foreign Months) Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 150 - 16 - 8388 150 7. Age (In yrs. last birthday) **Funeral** 1**M** 2□F 92 1913 SOUTH CAROLINA Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show other treumatic event, the Madical Examiner must be notified at **Funeral Director** 1 Nes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? ŏ 238 6000 BELLONA AVENUE filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 6 1 Yes 200No Specify: Completed by 3 X Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE MAN MONTGOMERI WARDS 18. Mother's Name (First, Middle, Maiden Sumame) (MN- LUNKNOZUK) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Importent: If item 27 is marked oth eny lighty or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be GEORGIANNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3621 LOCK WOOD ROAD, WOODLAWN, MD 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WESTERNSTAR 09-29-06 CATONSVILLE MC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN JR. FUNERAL HOME BALTO, Mp. 212 leamo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner PN EUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed NRIH AKY TRACT burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funers! [ 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Dav. Year) PHYSICIAN TENDING DOOG 2239. SEPTEMBER 25 2006 MARW NAING OO, MI 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Selta 4200. CHARLES 57. BATIMME MD 2/ 2014. 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 6 2006 Registrar

			For State Registrar	State	of Marylai		artment of F rtificate of		d Menta	al Hygiei Reg.		30467
			1. Decedent's Name (First, Middle	Last)						te of Death	Day Year	3. Time of Death
	Physici /Medic		Angelo J. Sgroi	_					Sept	2	8 <sup>ay</sup> 2006	2:05 P. M
	Examin	er	4a. Facility Name (If not institution,		umber)		4b. City, Town, o	r Location of D	eath		4c. County of De	
			Gilchrist Cente		7 Ago //p.vro	last hirthday)	Towson	If Under 24	Hrs I a Dat	e of Birth		e County
	uneral irector		5. Social Security Number 218-07-1107	6.Sex 12MM 2□F	7. Age (III y/s	. last birthday) Yrs.	Months Days			onth, Pay, Ye	920 Mar	irthplace (State or Foreign Sountry) Vland
			Usual Residence of Decedent								FIGE	y taria
rylan	how		10a. State 10b. County	C	1	ity, Town or Lo						10d. Inside City Limits
e Ma	Be-f.	Director	Maryland Baltim	ore coun	су го	ch Rave						1 ☐ Yes 2 🛣 No
with th	ben ben		10e. Street and Number 806 Shelley Roa	d			10f. Zip Code 21286				Citizen of What C ited Sta	-
eath	18 23.	Funeral	11. Marital Status		cedent Ever in I	J.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Ye		14. Race - Arr	
Ind 21215-0036  be filed within 72 hours after death with the Maryland	and Mediar hygiens in yeselves and Medical Examiner must be notified at aumatic event. The Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed F	orces? 2 ☐ No aive		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	uerto Rican,	etc.)	Black, Wh	nite, etc.
2 P	ical E	ted	15. Decedent (Specify only highes		n	16a. Dece	dent's Usual Occup	ation	working	16b	. Kind of Busines	s/Industry
<b>1</b>	Med L	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retire	d)	WORKING	M	ш х	
19 %	1. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2.		8	N/	A	Driv	/er	10 Mather's	Nome /First		·T·A·	
and Bedi	ed of	Be	17. Father's Name (First, Middle, & Thomas Sgroi	asi)				Venera			den Sumame)	
Maryland 21215-0036	in and Mer 7 is marke traumatic	၉	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Route	Number, Ci	ty or Town, State,	, Zip Code)
≥ ₽ :	27 is r trau		Mrs. Marianne T		aughter		Shelley					· - ·
altimore,	of Health litem 27 i rother tra	1 1	20a. Method of Disposition		_	cemetery, cres	sition (Name of matory or other place	ce)	Date		. Location - City of	or Town, State
MOr Pages	nt: ff int: ff iry or		1 ☐ Burial 2 🛱 Cremation 4 ☐ Donation 5 ☐ Other (Sp.		n State EV	ans Fur	neral Cha	pel Sep	ot. 24, 2006	, Fo	orest Hi	ll, Maryland
Baltimo	Department of importent: if it any injury or conce.		21. Signature of Funeral Service L	icensee		Pé	2. Name and Addre	ss of Facility 1ternat	ives H	unera	l&Cremat	ion Ctr. P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the dea						y ± ana / Z	Approximate Interval Between
Phy	ysician		Immediate Cause (Final disease or condition	,		5640	dder c	mee	D			Onset and Death
//\	<b>Nedical</b>		resulting in death)	Due to	(er as a conse			. ,,,,	/			7 7 7 0 7 0 7 0 0
EX	aminer		Sequentially list conditions,	b								
Pe	sit	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	quence of):						
xecut	and al-trar	Examin	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):						
8760, cate be executed	physicien and s the burial-transit	dicalE		d								
687	g phy as the	1 W 1		u							T	
Box death cert	ettending p I for use as	M/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic pregnancy	,			23d. Date of d	
I Records, P.O. Box 6 The law requires that the death certifi	he ett led fol	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)				Month	Day Year
P.O	signed by the e	된	9 Unknown			audiaa ia dha u		in Dani I	22	lo. Did tobas	L uso contributo	to the cause of death?
ies t	signe d be d	<u>م</u>	Part II. Other significant condition	, 0	a lune	suiting in the u	ngenying cause giv	en in Part I.	23	1 ☐ Yes	4	Probably 4 Unknown
OC .	should t	Completed	7	con s	7711012				_			•
Be is	2 5	ם							_ 24	<ul> <li>Was an autopsy performed</li> </ul>	prior to death?	autopsy findings available completion of cause of ?
<u> </u>	this certificete ha al director, page	ပို	25. Was case referred to medical		<del></del>		·	00 Diagram		Yes 2	No 1 □ Ye	es 2 No
sicie	is cert direct	To B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	000	Death (Chec		6 Other (Sp	pecity) HOSPICE
Vision of Vital	ter thi		27. Manner of Death	28a. Date	e of Injury onth, Day Year)	28b. Time o					njury occurred	3714-57
o e	death. ctor: After y the funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	min, buy rour,	injury		Yes 2□No				
Division of Vital Records, et or Attending Physician: The law requires the	s after death	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Plac	ce of Injury · At I ding, etc. (Spec		reet, factory, office			cation (Street y or Town, St		Rural Route Number,
• Hospit	within 24 hours after d  To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying (Cineck only one)	xaminer: On the	ne best of my kr basis of examin	nowledge, deat nation and/or in	h occurred at the till vestigation, in my o	me, date and p pinion, death o	place, and due occurred at th	e to the cause ne time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
To th	withir. To th	Me	29b. Signature and title of certifier	1 0			29c. Licens	e number			Date signed (Mon	
	, 1		Ill buth	- Mil	y me	9	Das	des		Sa	ptenle	0.20,2006
H	1		30. Name and address of person v		use of death (Ite	m 23a) (Type,	Print)	2 0				
ľ	1		31. Date filed (Month, Day, Year)	GBMC 32	6701 Registrar's Sign	N-Ch	er les St.	Palt	o mo	1 212	~ ×	
4	Sta Registi		SEP 2.6.7	No.	riogistrar s olgr	A AGE	Print) or (es St.					

			1 - For Amend item#23b-c	State of Marylar perFH,0859,9/26	nd / Depa	artmer <i>rtifica</i> i	nt of H te of L	ealth a Death	ınd Me	ental Hy	giene	2006	30	468
			1. Decedent's Name (First, Middle, Last	)					12	Date of De	ath	vi til	3. Time o	of Death
	Physici		Rebert Berno	ed Speed						Month Sept	Day 21	Year 2001	245	PM
	/Medio Examin		4a. Fecifity Name (If not institution, give			4b. City	Town, or	Location of	f Death	991	4c.	County of Deat	1	
1			Barenwood Nar	sing Home		Bal	time	ca			Λ	14		
	Funeral		<ol><li>Social Security Number 6. Se</li></ol>	7. Age (In yrs.	-	If Unde Months	r 1 Year	If Under 2 Hours	24 Hrs. 8	Date of Bird Month, Da	th y, Year)	9. Birti	nplace (State	or Foreign
	Director		218-12-2901	M 2 F 82	Yrs.					mar.	3/9	24	14	/d
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ncation							10d. Inside (	City Limits
	eho e	'n	11.0											s 2 No
	28a-1	Director	10e. Street and Number		Itimo		o Code			-T	10a Citi:	en of What Co	untry?	
	M P			٨							-		u, .	
	na 23	Funerai	28 40 Vicginia	12. Was Decedent Ever in t	J.S. 13.	Was Dece	215	spanic Orio	in? (Spec	ify Yes or No	US	4. Race - Ame	ncan Indian,	
(0	fler o	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, spe	cify Cuba	n, Mexican.	, Puerto Ri	ican, etc.)		Black, White	e, etc.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f ehow tha Madical Exemilier rival be mutilled at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	III	1 ☐ Yes	21 No	Specify:				Specify:	ack	
20	J within 72 hours piene. r then "naturel", ine Moules Exe	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usu	at Occupa	ation during most	of working	7	16b. Kir	nd of Business/	ndustry	
7	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)				luring most )						
		ပိ	UNK		Mec	nan	10			=	Sel	f Emp	oyed	
<u>n</u>	9 2 2 2	Be	17. Father's Name (First, Middle, Last)	1				-		First, Middle,	Maiden	Sumame)	•	
3	should by	၉	Joseph 1. Se		405 44:33			Bert		Why	_	T O		
Maryland	G 00 3	13	19a. Informant's Name/Relationship (T	/pe, Print)		400				_		Town, State, 2		and the
d)	l and least		Dato 715 Deech 20a. Method of Disposition	1 WIYE 20b.	Place of Dispo	osition (Na	rgiN me of	1	Da	te		_ <i>H cl</i> cation - City or		>
ğ	ages nt of t: if it		1 Burial 2 ☐ Cremation 3 ☐ F	Removal from State Ga	cemetery, cre	orest.	VA Ce	inetery	9/2	8/2006	/Owi	ngs Mill:	s, MD ,	
Baltimore	permit. Pages of Department of the important: If Ite any Injury or of once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service cons	طوالل المالية	diam's A	MA C	Burn	1214	12	Mar.		rris F	1	Hama
Ba	Depi impo		A Second							_		1tim pro		7:2.10
			23a. Part. Enter the disease, or comp	ications that caused the dea								12/1/100	Approxima	ate
	Physician		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	0 4	Do	elm	77					Interval Be Onset and	
	/Medical		disease or condition resulting in death)	a. Due to (or as a conse	quence of):	ja	CN WY							
	Examiner			Den	ented	7								
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of).									
	nd trans	Examiner	that initiated events	e ael	rexi	9								
30,	sate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):	77. (	an	(A	eid	السامل حك				
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dicai		d	ro vu	//W~	h	100		mi				
9	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancy					1904 111		04 Date 4 4 5		Y
Вох	atten for us	ian	in the past 12 months?	1 Live birth 2 ☐ Fet	at death 3[	☐Ectopic p☐ Other (s					2	3d. Date of deli Month	very Day	Year
o.	at the de by the stached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	302		DOUNY							
Ω.	that ed b	by Pt	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying	cause give	en in Part I.		23e. Did t	obacco u	se contribute to	the cause of	death?
rds	quires n sign uld be		1 byper for	FL						10	Yes 2	No 3□Pr	obably 4 🖰	Unknown
00	aw requir is been si 2 should	ojet	()							24a. Was		24b. Were au	topsy findings	s available
of Vital Records,	The la cate has page 2	Completed									osy ormed? 2 No	death?	omptetion of	cause of
ital		0	25. Was case referred to medical					26. Place	of Death (	Check only o		1.0.100	2010	
<b>†</b>	S 5	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 D	OA Othe	9r: 4 1 Nu	rsing Home	e 5 ☐ Resid	dence 6	☐Other (Spec	ify)	
0 _	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of finjury	of	28c. Injury Work	at	28	ld. Describe I	how injury	occurred		
Sio	Attendideath. ctor: A y the fu	cati	2 Accident investigation			М	1 🗆 '	Yes 2□N	No					
Division	or Attendation description of the Colorism of the cross o	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At In building, etc. (Spec	nome, farm, st ify)	reet, factor	ry, office		28	If. Location (3 City or Tox	Street and vn, State)	i Number or Ru	ral Route Nu	n <i>ber</i> ,
	ospital or A hours after uneral Dire		00a Cardillar MCCardifalon Phy	alalam. To the best of section				4						
	Ŧ 47 E 5	Medicai	29a. Certifier Certifying Phy (Cneck only one) 2 Medical Exam	sician: To the best of my kn iner: On the basis of examin and manner stated.	ation and/or in	vestigation	n, in my op	inion, deat	d place, an	at the time,	date and	and manner as place, and due	to the cause	(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				c. License					signed (Monti		
	0		I Dal	12V			D I	3141	64		9	25/0	6	
,	2 1	1	30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,									
0	<i>L</i>		SHOALIBA. HAS					St.	Sinte	308	BH	Lemok	e mi	215A
	Sta		31. Date filed (Month, Day, Year) SEP 2 6 200	32 Registrar's Sign	ature	and of								
	Registi	al	March 44 0 700	Se con a second second	A STATE OF THE PARTY OF THE PAR	- All Same								

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22**,**2006 September CLEO GRAY SIMPKINS 12:46PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June Day Year) 24 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours **X** M 2 □ F 227-22-8553 82 Yrs. Virginia Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode r then "neturel", or iteme 23s or 28s-f ebov the Medical Examiner must be notified at Baltimore Baltimore 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9713 Oak Summit Avenue 21234 hours efter death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: É 3 Widowed 4 □ Divorced Completed 12 should be filed within 72 har and Mental Hygiene. 7 Is marked other then "netui 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coppers Company Machinists Supervisor 12 17. Father's Name (First, Middle, Last)

Hamilton Simpkins 18. Mother's Name *(First, Middle, Maiden Surn*ame*)* Bertha Simpkins Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon Louise Simpkins permit. Pages 1 and 2::
Department of Health at Importent: If Item 27 is any Injury or other traugues. 9735 Magledt Road-Parkville, Maryland 21234 20b. Place of Disposition (Name of 9-26-06 20c. Location - City or Town, State 20a. Method of Disposition Gardens Of Faith W Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, Maryland 4 □ Donation 5 □ Other (Specify) Cemetery 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, Maryland 21234 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ymphoma disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the at d be detached for 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗀 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO3714 1 Yes 35 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred : After Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58303 September 22 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GGOI N- Charles St Browne un 2/204 men (harles un 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DENEZ SEP 2 6 2006 Registrar

DHMH 17 Rev 1/2001

		For Amend #4a	i per-rin	ייצנטטיי	2 <del>97</del> 2 <del>0</del> 7 C	ertifica	ite of	Deat	h h	101,1141111	Reg. No	20	06	3047
		Decedent's Name (First, Middle, I	Last)							2. Date of D	eath		V02-	3. Time of Death
Physicia /Medic		MILDRED V	/IRGINIA	SHIPLE	Y					Month DeDte	Da nselm		700k	8:13 8
Examin		4a. Facility Name (If not institution, of 3608 Cottage	ive street and nui	mber)		4b. Cit	y, Town, o	r Locatio	n of Death		4c	. County of	Death	
		STACT FLOOR TO	tob bal	7. Age (In yrs.	Last highd		ler 1 Year	V Ove	er 24 Hrs.	8. Date of Bi	-th	N/		ana (State or Fare)
Funeral Director			Sex 1 □ M 2XOXF		V	Month				(Month, D	ay, Year)		Count	**
sne. then 'natural', or itame 23s or 28s-f show the Medical Exactinat must be notified at		216-42-2312 Usual Residence of Decedent			59 ''s	i				OCT 2	T 19	46	MAR	YLAND
Mot 1		10a. State 10b. County		10c. C	ty, Town or	Location							10	d. Inside City Limi
= =	to	MARYLAND N/A			BALTI	MORE								1 ∑ Yes 2 □ N
128	Director	10e. Street and Number	1				Zip Code				10g. Cit	tizen of Wh	nat Count	try?
238 0		3608 COTTAGE	AVENUE				21	.215			Ţ	J.S.A		
and Mental Hygiene. Is marked other then "natural", or iteme 23s or 28s-f show sumatic event, the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	J.S. 1	3. Was Dec	edent of h	Hispanic (	Origin? (Spi	ecify Yes or N Rican, etc.)	0-	14. Race	- America White, e	
a a		1 X Never Married 2 ☐ Married		2 🔀 No			2 🔯 No					Specify:		
E	d by	3 Widowed 4 Divorced	Year or D	ates:								opedity.	BLA	CK
nati	Completed	15. Decedent's (Specify only highest of			(G	cedent's Us ive kind of y	vork done	during m	ost of work	ing	16b. K	and of Busi	iness/Ind	ustry
ne Ma	ם	Elementary/Secondary (0-12)	College (	1-4or 5+)		a. DO NOT					Cr	מאמים	OE M	ARYLAND
nt.		12th grade  17. Father's Name (First, Middle, La	4yrs	5	CAS	SE_CO	ORDIN			e (First, Middle				ARILAND
o pe	Be		31)									, Jamaine,	/	
nark	T <sub>0</sub>	ROBERT ALFORD  19a, Informant's Name/Relationship	(Tuna Print)		10h M	siling Addro	on /Strant			ATKINS		or Tourn S	tato Zin	Codol
7 le r														
Item 27 is marke		Keith A Jones/Ne 20a. Method of Disposition	phew	20b.	806 Place of Dis			d.,		more, Moate		Land : ocation - C		
1 0		1XX Burial 2 ☐ Cremation 3		State	cemetery, c	rematory o	r other pla	ce)	00.0	0.06				
njury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Liq		M.T.	ZION				09-2	9-06	LANS	SDOWN	E, M	ARYLAND
Importent: If Item 27 is any Injury or other tre		21. Signature of Funesal Service Lit	580		Į.	22. Name VILLIA 1 2 0 6	AM C	BROW	N COM AVENU	MUNITY	FUNE	ERAL I	HOME	P.A.
		234 Part1 Enter the disease or d	molications that o	aused the dea	th. Do not						arrest			Approximate
		23a. Part1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final	ly one cause on e	each line.				3,						Interval Between Onset and Death
sician edical		disease or condition resulting in death)	a	a any										6mils
miner				(or as a colorle	~ -									Lkou
	F	Sequentially list conditions, if any, leading to immediate	D	(or as a consec										Jang
burial-transit	E L	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Rith									-	year.
al-tra	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consec	quence of):									1
	dlcall		ч											
g physi	edlo		J											
attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			o □ <b>c</b>						23d. Date	of deliver	у
d for	cla	in the past 12 months? 1 □ Yes 2 □ No	4□Pregr	oirth 2 ☐ Feta nant at time of o		3 □Ectopic 5 □ Other (		у				Montl	h I	Day Year
deteched	hys	9 □ Unknown	9□ Unkn	own										
gned be de	by P	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the	a underlying	g cause gn	ven in Pa	rt I.	23e. Did	tobacco i	use contrib	ute to the	e cause of death?
been sig	edi									1 🗆	Yes 2	□No 3	☐ Proba	ibly 4 Unkno
s bee	Completed									24a. Wa:		24b. We	ere autop	sy findings availa
age 2	E									auto perf 1 ☐ Yes	ormed? 2 No	de	ath?	npletion of cause o 2∭No
tor, p	0	25. Was case referred to medical	T					26. Pla	ice of Death	Check only	_/_	,		2,30110
is ce	To B	examiner? 1 ☐ Yes 2 ☐ RNo	Hospital: 1 🗆	Inpatient 2	] ER/Outpat	tient 3 1	Ott	ner: 4 🗆	Nursing Ho	me 5 Res	idence	6 □Other	(Specify	)
ter th		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time Injur		28c. Inju	ry at		28d. Describe				
or: Af	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigat	ion	,, ,,	,	м		Yes 2	□No					
by th	tifle	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At h	ome, farm,	street, fact	ory, office			28f. Location City or To			or Rural	Route Number,
e e	Certification:				.,,						,	-,		
o the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the aminer: On the b	best of my kn	owledge, de	ath occurre	ed at the ti	me, date	and place,	and due to the	cause(s	) and mann	ner as sta	ited.
To the Funeral Director: A completely filled in by the funeral completely filled in the funeral completely filled in	edl	one)	and man	ner stated.						es at the time				``
To the	Σ	29b. Signature and title of certifier		<b>5</b> .			9c. Licens	se numbe	r A 22 /		13 .	te signed (		
7		1 miles	Than	Poon 1	mD (F	ACI	D	2 (	022		<b>Sept</b>	mbeu	25	2006
		30. Name and address of person wh	o completed caus	of death (Ite	m 23a) (Typ	e, Print)	0	0.		*				( )
				Paw Pla		4 701	13	2 年	WON!	my 2	1201	<u></u>		
		31. Date filed (Month, Day, Year)	32 F	legistrar's Sign	ature 🥒									

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last	State of Marylan	Cei	tificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
Physic /Medi Examir	cal	William J. Sho	street and number)			or Location of Death		23°, 2006 4c. County of Dea	
Funeral Director		Stella Maris Ho  5. Social Security Number 176-20-4001 10		last birthday) Yrs.	TOWSOI		8. Date of Birti Month Day July 25	Baltimo	ore thplace (State or Foreign puntry) Insylvania
ד	Director	Usual Residence of Decedent  10a. State 10b. County  MD Baltin		y, Town or Lo	River				10d. Inside City Limits 1 ☐ Yes ※ No
th with the 23a or 2	rai Dire	10e. Street and Number 12904 Harewood	d Road		10f. Zip Code 2122	20		10g. Citizen of What Co USA	ountry?
s 1 and 2 should be filed within 72 hours after death with the Maryland if the 21th and Mental Hygiene. If the 27 le marked other than "natural", or Iteme 23a or 28a-f ehow other traumatic event, the Macical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes Art No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub I ☐ Yes 2 🗓 No	Hispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
e field within 72 hours at all Hygiene. other than "natural", or vent, the Medical Exami	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 1 2	ication fe completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of word d)		16b. Kind of Business  Glenn L.	
uld be filed Mental Hygi irked other itic event, ll	To Be Co	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Nam Wilma M	ne (First, Middle,	Maiden Sumame)	
and 2 sho selth and h n 27 le ma ler trauma		19a. Informant's Name/Relationship (T Marsha Mank	Daughter	2609	Hillc	rest Ave		r, City or Town, State, MOre, MD	21234
permit. Pages 1 at Department of Hee Important: If item eny injury or othe once.	1	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,	Bay	yview		ory   09/2		20c. Location - City or Baltimore	e, MD
Departition Departition on the contraction of the c		21. Signature of Funeral Service Licens	melly					Ave Balt of Essex	21221
Citicate be executed / Medical Examiner as the burial-transit	edical Examiner	23a. Part1. Enter the disease of compositors, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. BLADDER CAN Due to (or as a conseq  b. Due to (or as a conseq  c. Due to (or as a conseq  d.	uence of):	ar the mode or dys	ig, such as carried	опевриаютуа	(GS),	Approximate Interval Between Onset and Death
death cer e attendir id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
requires that the leen signed by th hould be detache	b	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.		obacco use contribute to res 2 □ No 3 □ P	o the cause of death?
Page Page	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was autop perfor 1 Yes	sy prior to death? 2 No 1 ☐ Yes	utopsy findings available completion of cause of
tending Physideath. tor: After this the funeral di	Certification: To B	examiner?  1  Yes 2  No  27. Manner of Death  1 Natural 5  Pending investigation  3  Suicide 6  Could not be 4  Homicide determined	Hospital: 1 Inpatient 2 Inpati	ER/Outpatien 28b. Time of Injury ome, farm, str	28c. Inju Wo M 1	ner: 4 Nursing H	ome 5 Resid	ence 6 NOther (Specow injury occurred	
To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29a. Certifier Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, death tion and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of partitier  30. Name and address of person who c	omoleted cause of death (Item	n 23a) (Type		se number		29d. Date signed (Mont	
Sta Regist	ate rar	DR. TARIQ MAHMOOI  31. Date filed (Month, Day, Year)	2300 DULANE 32. Registrar's Signa	Y VALL	EY RD.	TIMONIUM,	MD 2109	93	
HMH 17 Rev 1/2	2001	JET 6 0 L	And I want	* *					

DHMH 17 Rev 1/2001

12:20 а.ш.

2006

SEPTEMBER 23,

WILLIAM SHOTKOSKY

State of Maryland / Department of Health and Mental Hygiene 2006Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Tina M. Sturgeon 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Squ tospital Baltimore Rosedale raire If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 216-68-4208 48 Yrs. Director Nov.4,1957 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at Essex Baltimore MD Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 302 Locust Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 ☐ Yes 2 XNo Specify:White ξ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be be be partment of Health and Mental himportant: if Item 27 is marked oth any injury or other traumait. Rose Marie Blakemore Harvey Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Locust Ave. Baltimore MD 21221 19a. Informant's Name/Relationship (Type, Print) Mike Poling 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Bayview Crematory 9/26/06 1 □ Burial 2X Cremation 3 □ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 d ER/Outpatient Medical Certification: To 3□ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 3 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge death occurred at the time date and disce and due to the cause(s) and manner at stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

SEP 2 6 2006

31. Date filed (Month, Day, Year)

Urgeon, Lind ore, Maryland 21215-0036

Baltimore,

Box 68760. P.O. Records. Division of Vital

_			State Registrar	State of Maryland	Depa Ce	artment of H	Death	Reg.	ne 2001	5 30473
1	Physicia		1. Decedent's Name (First, Middle, Las $George  J  .$	Stevenson				2. Date of Death Month Sept. 20	Day 2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Essex	r Location of Death		4c. County of Deat Baltimo	
Ī	Funeral Director		B 1 B 0 1 B 0	7. Age (In yrs. In YM 2 F		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 11	9. Birth Co , 1943 Ma	nplace (State or Foreign untry) ryland
	Maryland 9-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Balti		Town or Lo		<del></del>			10d. Inside City Limits 1 ☐ Yes 🏖 No
	th with the 23a or 28e ust be noti	al Director	10e. Street and Number 329 Stillwate	r Road		10f. Zip Code 21	1221		Citizen of What Co JSA	untry?
036	be filed within 72 hours after deeth with the Maryland Ital Hygiene. Id other then "natural", or Iteme 23a or 28e-f show event, Ite Medical Examination must be motified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.3 Armed Forces? 1 ☐ Yes 2★☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
altimore, Maryland 21215-0036	within 72 ho ene. then "natur te Medicel	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4or 5+)	(Give lite.	dent's Usual Occup kind of work done o DO NOT use retired nter	ation during most of workin f)	g i	Daily Re	cord Co.
/land 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other treumatic event, the Magnee.	To Be C	17. Father's Name (First, Middle, Last) George F. Ste	venson			18. Mother's Name Joseph:	(First, Middle, Mai ine M.		
Man	alth and I		19a. Informant's Name/Relationship (7 Sandra Stevens	on/wife	329	Stillwa	and Number or Rural ater Road	Route Number, C d Baltin	ity or Town, State, 2 more MD	<sup>(ip Code)</sup> 21 2 2 1
imore	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition  ¶☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Gai	ace of Dispo emetery, crei dens	osition (Name of matory or other place of Fail	<sup>b</sup> h 9/2		S. Location - City or DSSVille	•
Balt	permit. Departr Imports any inje		21. Signature of Funeral Service Licens	ry Consi	lly	2. Name and Addre	300 y Funera	1 Home	Ave. Bal of Esse	
9	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	ilications that caused the death cause on each line.  a	MA	ter the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death US ARS
68760,	ificate be executed was physician end as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. To 3 A c c o  Due to (or as a consequence)  Oue to (or as a consequence)	uence of):	803E				yeurs
.O. Box 687	the death cert y the ettendin iched for use	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date ol del Month	very Day Year
rds, P	quires that in signed t uld be det	ed by P	Part II. Other significant conditions or	ontributing to death but not resu	ulting in the u	inderlying cause giv	en in Part I.	_		the cause of death?
l Reco	Physician: The law requires that this certificate has been signed brial director, page 2 should be determal	Completed						24a. Was an autopsy performed	d?   death?	topsy findings available completion of cause of
Vita V	iclan: certific actor,	Be	25. Was case referred to medical examiner?	Hospital:		ot 3 DOA Oth	26. Place of Death			
o t	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	1 3 DON	4   Italiang Hon	ne 5 Residenc 8d. Describe how	e 6 Other (Specially)	city)
You to me / M	deat deat ctor: y tha	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		Injury me, farm, str	M 1 🗆	Yes 2 □No	81. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical Ce		ysicien: To the best of my knor iner: On the basis of examinat and manner stated.						
	To th within To th	Me	29b. Signature and title of certifier	Polist me		29c. Licens	e number 3634	29d.	Date signed (Monta	n. Day, Year)
_	10 '		30. Name and address of person who of PAVID ZOLE	Timb 910s	FRA	Print)	Sounce	DR #30	59 BAU	~D 21237
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 20	32. Registrar's Signa	ture	elle				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 30474 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician drec 2006 Hember 24 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Smoord 5. Social Security Number 7. Abe (In yrs. lest birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours 1□ M 2□XF Months Yrs. 212-24-9392 Director 79 06/02/1927 NC Usuel Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. important: If itam 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumetic event, the Medical Evantmer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore City N Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Bolton Street 21201 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: Black 3 X Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) n/a In-Home Aid State of Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Floyd Harding Grace Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martines Banks / Son 1923 Homewood Avenue; Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 10/03/2006 Baltimore, Maryland 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 Mias 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Nnknown 1 ☐ Yes 2 ☐ No director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? 215 No 1 TYAS 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Certification: To 3 DOA After this fillad in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injun within 24 hours after death. To the Funeral Director: A investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signature and title of certifier 25 200k 5 Name and address of person who completed cause of death (Item 23a) (Type, Print) GAU, 31. Date lied (Month, Day, Year) SEP 2 6 2006 32 Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			1 - State Registrar	Otate of Maryland / L	Certificate of Death		ene2006 30475
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	
d	/Medi	cal	Helen M. Spange				23, 2006 2:00 PM
4	Examir	ner	403 N • Beechwoo		4b. City, Town, or Location of Dea		4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 2 1 6 − 0 1 − 8 4 5 6	7. Age (In yrs. last bin	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) MD
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d, Inside City Limits
	Maryl -f sho	to	MD . Baltimor				1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Number	ou como	10f. Zip Code	10	g. Citizen of What Country?
	23e c	alD	403 N. Beechwoo	od Avenue	21228		USA
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 ie marked other than "neturel", or Items 23e or 28e-f show any injury or other traumatic event, tre Madical Examination, use the multiple at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces?     □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (stiff Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race · American Indian, Black, White, etc.  Specify: White
2	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work)	dring 1	6b. Kind of Business/Industry
12	within na. han *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	, King	Orrm II am a
р Б	Hygie other t	ပိ	17. Father's Name (First, Middle, Last)		Homemaker	me (First, Middle, M	Own Home
Maryland	should be fand Mental Permarked of	To Be	Clinkner Ehrli	ch			
ary	shou and M e mar umati	-	19a. Informant's Name/Relationship (Typ	e, Print) 19b.		ıret Unkı ural Route Number,	n own City or Town, State, Zip Code) 21228
	and 2 ealth a n 27 le		Lynn E. Wilkinso	The second secon			
ore	Pages 1 nent of He int: If iter		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Re	moval from State cemeter	Disposition (Name of y, crematory or other place)		0c. Location - City or Town, State
altimore,	t. Pag tment tant: ijury o		'4 □Donation 5 □Other (Specify)	рауу	iew Crematory 9-		Baltimore, MD
Ba	permit. Departr Imports any inji		21. Signature of Funeral Service Licenses	<del></del>	PA, 2134 Willow	Spring	shton Funeral Home Rd., 21222
68760,	/Medical Examiner the bruial-transit the bruial-transit	Medical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of Due to (or as a consequence of	of enter the mode of dying, such as cardia the further lung of the further lung of the further distribution of the	e disco	Approximate Interval Between Onset and Death  August 1  Approximate Interval Between Onset and Death  August 1  Approximate Interval Between Onset and Death  August 1  Approximate Interval Between Onset and Death  August 1  Approximate Interval Between Onset Interval Between
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 □ Yes 20 No 9 □ Unknown	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	w requires the been signed should be de	by	Part II. Other significant conditions conti	ributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?  2 \( \sum \text{No} \) 3 \( \sum \text{Probably} \) 4 \( \sum \text{Unknown} \)
Vital Records,		Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:		th (Check only one)	
Ö	Phye	To To	1 ☐ Yes 2 No Ho  27. Manner of Death	1   Inpatient 2   ER/Out	patient 3 DOA Other: 4 Nursing H	lome 5 Resident	ce 6 Other (Specify)
0	nding I tth. r: After e funar	atlor	1 Natural 5 Pending 2 Accident investigation		ime of 28c. Injury at work?  M 1 Yes 2 No	200. 2000/150 110 10	injury occurred
DIVISION	or Atter ifter dea Director in by the	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
_	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical Ce	29a. Certifier Certifying Physic (Check only 2 Medical Examine	cien: To the best of my knowledge,	death occurred at the time, date and place	, and due to the cau	se(s) and manner as stated.
	the hin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		
	F × F 8		250. Signature and time of dominion	mphysi's	uán D297	691	I. Date signed (Month, Day, Year)
	X	ļ.,	30. Name and address of person who com	my 5/6.	N. Rollin Pd	Bali	4 had 21228
	Sta Registr		31. Date filed (Menth, Day, Year) SEP 2 6 20	32. Régistrar's Signature	franks 1		

For	State of Maryland / Department of Health and Me
State	Cartificate of Death

		•	For State Registrar		State o	f Maryland	d'/ Depa <i>Cei</i>	artment of F tificate of	léalth ai <i>Death</i>	nd Me	ntal Hy	giene Reg. No.	2006	30476
	Physici /Medie		Decedent's Name (First	st, <i>Middl</i> e, Las BERTHA	•			SCHOR			Date of Dea	22, Day	2006 <sup>Year</sup>	3. Time of Death 10:15 — M
	Examir		4a. Facility Name (If not in 6001 PARK	HEIGHT	S AVENU	IE #10		4b. City, Town, o	BALTI	MORE			County of Death	N/A
	Funeral Director		5. Social Security Numbe  088-22-660  Usual Residence of Dece	2 1	ex □M 2 <b>∏</b> F	7. Age (In yrs. Ia	* .	If Under 1 Year Months Days			Date of Birt 1808 137	1917	9. Birth	nplace (State or Foreign untry) NY
	Maryland f show	ŏ		County	/A	10c. City	, Town or Lo	cation						10d. Inside City Limits 1 X Yes 2 □ No
	with the 1 3a or 28a-	Funeral Director	10e. Street and Number 6001 PARK			JE #10		10f. Zip Code	21215	<u> </u>		10g. Citiz	en of What Co	untry?
036	be filed within 72 hours after death with the Maryland hat Hygiene. d other then "natural", or items 23a or 28a-1 show event, I'm Medical Exartinal for publical at		11. Marital Status  1 □ Never Married 2 3 🗷 Widowed 4 □ □	2□ Married		edent Ever in U.S rces? 2 [X] No	-	Was Decedent of If Yes, specify Cub		in? (Specif Puerto Ric	y Yes or No- can, etc.)		4. Race - Amer Black, White Specify:	
21215-0036	- 1	Completed by	15. I (Specity on Elementary/Secondary		lucation de completed) College (1	-4or 5+)	(Give	tent's Usual Occup kind of work done DO NOT use retire	durina most o	of working			HOME	Industry
Maryland	should be filed withir nd Mental Hygiene. s marked other then umatic event, it a M	To Be (	17. Father's Name (First, GUS	Middle, Last)			LEVY	,	18. Mother's		First, Middle,	Maiden :		DSTEIN
	d 2 is 27 is trau		19a. Informant's Name/P				6016	ng Address (Street CLOVER R						(ip Code)
Baltimore,	Pages nent o ant: if ury or		20a. Method of Disposition  1 Burial 2 Cre 4 Donation 5 0	mation 3 [		State CE	emetery, cren	sition (Name of matory or other pla CHAIM CEM		9/25,			SHEMES	Town, State SH, ISRAEL
Balt	permit. Departr imports any inje		21. Signatury of Funedal	Service Vicer	SM	ger		Name and Address Name and REIS					& BROS. SVILLE,	, INC. MD 21208
	Physician /Medical		23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or compare. List only	one cause on e	ach line.	IC ST	er the mode of dyi		ardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	rcate be executed by physician and burial-transit of	dical Examiner	Sequentially list condition if any, leading to immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, ate	c	or as a consequ								
Box (	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 □ Yes 2 □ No 9 □ Unknown		1 Live b	come of pregnar iirth 2  Fetal ant at time of de	death 3	Ectopic pregnanc	у			2	3d. Date of deli	very Day Year
ds, P.O.	juires that the de n signed by the a lid be detached t	ρ	Part II. Other significant	conditions c	ontributing to de	eath but not resu	ılting in the uı	nderlying cause gr	ven in Part I.					the cause of death?
of Vital Records,	ysician: The law requires that the is certificate has been signed by th director, page 2 should be detache	Completed									24a. Was autop perfor 1 Yes		prior to c death?	topsy findings available completion of cause of
Vita	Physiclan: Th this certificate ral director, pag	) Be	25. Was case referred to examiner?  1 ☐ Yes 2 ☑ No	medical	Hospital:		F0/0	-5 -5. Ot	200		Check only o			
	ਦੂ ≑ ਫ਼	atlon; To	27. Manner of Death	Pending investigation	28a. Date (Mon	npatient 2   I of Injury th, Day Year)	28b. Time of Injury	28c. Inju Wo		280	d. Describe h		Other (Spec	iny)
Division	tal or Attences after death	Certification;	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, office		28f	Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medicai	(Check only 2 ]   one)	Medical Exan	niner: On the b	best of my know asis of examinat ner stated.	wledge, death ion and/or in	occurred at the to vestigation, in my	opinion, death	place, and occurred	at the time,	date and	place, and due	to the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of		_			29c. Licens					signed (Month	n, Day, Year)
5	7		30. Name and address of Robert M. C		completed caus	204011	14=101	Print)	· · ·	ATIL	IONE			. —
	Sta	te	31. Date filed (Month, Da		34 R	egistrar's Signat	ture	M	2 107		7010	VV(1	0.212	.13
	Regist		ŜEP	2 6 200	6	was St.	April	المالية				-		

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland /	Departr <i>Certifi</i>	ment of He icate of D	ealth and N Death		gieneZ Reg. No.	2006	30477
Ę	- 19 a	9,	1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		Jason Bryan S	pencer					Septem			0 3:27 PM
	Examin		4a. Facility Name (If not institution,	give street and number)				Location of Death	•	4c. C	ounty of Death	n
\$200 100		禁坑	Sinai Hospital				Baltim Under 1 Year	If Under 24 Hrs.	100 (0)		n/a	
8	Funeral		,	1 <b>∑</b> M 2□F	(In yrs. last		onths Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)		nplace (State or Foreign untry)
	Director	1	216-27-2543 Usual Residence of Decedent		L8				10-12	-198	/Má	ryland
	yland yland		10a. State 10b. County			own or Location						10d. Inside City Limits
	a-f sl	ctor	MD Balti	more	Rand	dallst	town					1 ☐ Yes 2 XNo
	th with the 23a or 28	Funeral Director	10e. Street and Number 4217 Herrer	a Court		1	of. Zip Code 21133				on of What Cor USA	untry?
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show emprotant: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Madical Examinar natal be notified at once.	þ	11. Marital Status  1 Wever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:			Decedent of His s, specify Cubar Yes 2 No	spanic Origin? (Sp., Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		Black, White Afric Apecify: Ame	, etc.
5-0	72 h	etec	15. Decedent's (Specify only highest	Education grade completed)	16	6a. Decedent' (Give kind	s Usual Occupa of work done di	tion uring most of wor	king	16b. Kind	d of Business/I	ndustry
21	tiled within Hygiene. other than other, Ire Mag	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Stude	ent				ollege	2
Maryland	uld be tild Mental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, La D'Artagnan E.					18. Mother's Nam Michel	ne (First, Middle, 1e R			
ary	2 should and Men is marke		19a. Informant's Name/Relationshi				·	nd Number or Ru				
	and sealth m 27		D'Artagnan E.		- Indian			a Ct.,	-			
Baltimore,	f of H if ite		20a. Method of Disposition Ent 1 ☐ Burial 2 ☐ Cremation		20b. Place	of Disposition etery, cremato	n (Name of ry or other place		Date	20c. Loca	ation - City or 1	Town, State
tim	tent:		4 □Donation 5 XOther (Spe	ocity)	Wood		Cemete		27/06		dlawn,	
Bal	permit. Departr Importe any inji		21. Signature of Funeral Service Li	censee								Balto.Co. MD 21133
	Observation		23a. 11. Enter the disease of shock the failure. List of Immediate Cause (Final				Company of the Compan		4			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)					and n				1 month
5.67	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	diac	meta	stases	, hear	t bl	ock	7 months
3.	ficate be executed physicien end is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	2av	cell	serc	ona				2/2 years
68760,	e be e. rsicien e buria	calE		d.							11	
	tificat ng phy as th											
O. Box	that the death certifi ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		opic pregnancy ner (specify)			23	d. Date of deli Month	very Day Year
٩.	iaw requires that the as been signed by th 2 should be detache	by Ph	Part II. Dther significant condition	s contributing to death be	ut not resultin	g in the under	lying cause give	n in Part I.	23e. Did to	obacco use	e contribute to	the cause of death?
rds	w requires been sig should b	ed b							101	∕es 2 🕟	√No 3 Pro	bably 4 Unknown
of Vital Records,	The ate has page	Completed									prior to c death?	opsy findings available ompletion of cause of
/ita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?					26. Place of Dea				
JC/	Physi this o	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie			DOA Othe	4 □ Nursing H	ome 5 Resid			ify)
	Attending Production of the color: After by the funeral	ation:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		Year) 28t	b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 □No	28d. Describe h	now injury	occurred	
Division	s after de s after de al Directo ad in by t	Certification:	3 Suicide 6 Could no 4 Homicide determin			, farm, street,	factory, office		28f. Location (S City or Tox		Number or Ru	ral Route Number,
	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of kaminer: On the basis of and manner sta	examination	dge, death occ and/or investi	curred at the time gation, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	-01		Į.	29c. License	number		29d. Date	signed (Month	, Day, Year)
			Charlott	esphelism	an	- MD	Dic	11128		Septer	nber 2	1,2006
	60		30. Name and address of person we Charlotte Glicks M				iene An	re. R.	ret. M	ત . ત્ર	11215	,
1	Sta	ite ar	31. Date filed (Month Pay, Year)		ar's Signature		MP .				-	

Jason B. Speneer

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19b periff, 6859, 9/26/06 WS

Amend #5 per FH 6859/26/06 Penartment of Health and Mental Hygiene 2 0 0 6

Certificate of Death

Reg. No. 30478 For State Registrar 1 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Car 4143PM September 20 2006 *Inompson* /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Christ 20-6432 Towson Baltimore Nursing 6. Sex Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036

**Funeral** Director

Pnysician /Medical Examiner

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	216 20	132	1 <b>X</b> M 2□F	76	Yrs.	Months Days	Hours	Min.	(Month, Day, Year 12 · 4 · 192	9	MD MD		
	Usual Residence of 10a. State	10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limits		
ğ	MD			P	BILL	more					1 ☐ Yes 2 No		
rec	10e. Street and Nu	mber			WITI.	10f. Zip Code			10g. C	itizen of What	Country?		
0	4112 F	mmart	Ave			213	15			11.5.	A		
ner	11. Marital Status	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12. Was Decede	ent Ever in U.S.	13. W	as Decedent of F Yes, specify Cub	lispanic Orig	in? (Specify	Yes or No-		nerican Indian,		
린	1 🗌 Never Marr	ied 2 Married				☐ Yes 2 No	Specify:	Fuelto Hic	ari, etc./	Black, Wi	nite, etc.		
o b	3 Widowed		Year or Date							Specify 3	ack		
ete	(Spec	15. Decedent's cify only highest of	Education rade completed)	1	6a. Decede (Give k	ent's Usual Occup and of work done O NOT use retire	during most	of working	16b. i	Kind of Busines	ss/Industry		
Ĕ	Elementary/Seco	4 4 1	College (1-4	or 5+)	,	gshore			7	-10	4952		
Be Completed by Funeral Director	17. Father's Name		st)		101	gonore		's Name (F	irst, Middle, Maide	n Sumame)	100		
To B	Carl F.	Thomas	50m. Br.				Tive	2 fe	untain	1			
	19a. Informant's N			1	9b. Mailing	Address (Street	and Number		oute Number, City	or Town, State	, Zip Code)		
	Mary T.	Thoma	son/Wife	e	401	l3 Emmar	t Ave.	Ba1	timore, 1	MD. 212	15		
	20a. Method of Dis		☐Removal from Sta	1 0000	of Dispos etery, crem	ition (Name of atory or other pla	сө)	Date	20c. L	ocation - City	or Town, State		
		5 Other (Spec		"Bren	iers l	till Ceme	tery C	7.25	06 An	napoli:	mD.		
	21. Signature of Fu	neral Service Lic	ensee		22.	Name and Addre	ss of Facility	vau	hn C. Gi	eene f	mD uneral service		
-1	Van	yh (	· 4n-	2				Kande	1115town	mD 2	1133		
	shock, or hea	irt failure. List on	mplications that cau y one cause on eac	sed the death. (i h line.	o not ente	r the mode of dyli	ng, such as c	ardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)												
	Due to (or as a consequence of):												
ē	Sequentially list conditions, if any, leading to inmediate Due to (or as a consequence of).												
Ē	Cause (Disease or	ertying	`										
Exa	that initiated events resulting in death)	Last	c Due to (or	as a consequen	ce of):								
cal			d.										
Ned	IF FEMALE:												
an/	23b. Was deceden in the past 12		23c. If yes, outcom 1 ☐ Live birth	me of pregnancy 2 Fetal dea		Ectopic pregnanc	y			23d. Date of o	•		
/sici	1 ☐ Yes 2 [ 9 ☐ Unknown	□No	4□Pregnan 9□Unknow	t at time of death	1 5□	Other (specify) _				MOHIII	Day Year		
pieted by Physician/Medical Examiner		'	contributing to deat	h but not resultin	a in the una	deriving cause gr	en in Part I		23e. Did tobacco	use contribute	to the cause of death?		
D D			<b>3</b>		<b>3 2</b>	, <b>.</b>					Probably 4 □Unknown		
ete									1	Odb Moss			
E C									24a. Was an autopsy performed?	prior to	autopsy findings available completion of cause of		
Com	25. Was case refer	read to medical					Acres 1		performed? 1☐ Yes 2. ☐ N	1 🗆 Y	es 2 No		
o Be	examiner?		Hospital:	ations OFF	(Out-ati-at	ou not			heck only one)		· Carron S		
٠. To	27. Manner of Deat		1 ☐ Inp	njury 28I	Outpatient  b. Time of	3□ DOA 28c. Injui Wo	4∐ Nur ryat		. Describe how inju		pocity Muspie		
ğ	1 Natural 2 Accident	5 Pending investigat		Day Year)	Injury		rk? ∣Yes 2.∐N			,			
<u>2</u>	3 Suicide	6 Could not determine	d 28e. Place of	Injury - At home	, farm, stre	et, factory, office		28f.	Location (Street a	nd Number or	Rural Route Number,		
er.	4 [] Homicide		building,	etc. (Specify)					City or Town, Stat	θ)			
Medical Certification;	29a. Certifier (Check only one)	Certifying I	Physician: To the beaminer: On the basi and manner	s of examination	dge, death and/or inve	occurred at the tilestigation, in my o	me, date and opinion, death	place, and occurred a	due to the cause(s	and manner d place, and d	as stated. ue to the cause(s)		
ž	29b. Signature and	title of certifier	\			29c. Licens					nth, Day, Year)		
	MAK	ran	Lung			DS	5830	3	Sep	tember	-212006		
	30. Name and addr	ress of person wh	completed cause	of death (Item 23	a) (Type, P	rint)		-			201 2006		
	Amon	Charl	es, mo	6601	N	Charl	es St	VSAC	more in	0) 21	209		
	31. Date filed (Mon	th, Day, Year)	#32. Reg	strar's Signature	1	W .							

Sta

Registrar

SEP 2 6 2006

			1 - For State Registrar	State o	of Maryland / De	partment of <i>ertificate c</i>	Health a If Death	and M		gienez Reg. No.	006	30	479
	Physici	an	1. Decedent's Name (First, Midd						2. Date of De.	ath Day	Year	3. Time o	of Death
	/Medic			0	urner				Septemb			7:05	P M
	Examir	ier	4a. Facility Name (If not institution		•		n, or Location o				unty of Death		
4			Future Care Nu  5. Social Security Number	6. Sex	111ty 7. Age (In yrs. last birthdi		ndallst		0 Data of Bid		ltimore		
	Funeral Director		215-28-5194	1 □ M 2 TF	90 Yrs	Months Day		Min.	8. Date of Birt (Month, Da 12/06/1	y, Year)	Cou		or Foreign
L.K.	Ü		Usual Residence of Decedent						12/00/1	.915	Virg	ınıa	
	anylar	٠.	10a. State 10b. Count	у	10c. City, Town or							10d. Inside C	•
	88a-f	Director	Maryland		ват	timore						1 X Yes	2 No
	with the	급	10e. Street and Number			10f. Zip Code				10g. Citizen	of What Cou	ntry?	
	eath	Funeral	2322 Koko Lane		edent Ever in U.S. 1		1216	ain? /Coo	oifu Vaa ar Na	U.S.A		non Indian	
10	r Iten	Fun	1 Never Married 2 Ma	Armed Fo	orces?	<ol> <li>Was Decedent of if Yes, specify C</li> </ol>		gin? (Spe ), Puerto	Rican, etc.)	14.	Race - Ameri Black, White,		
98	al', o	þ	3 XWidowed 4 ☐ Divorce	If Vac Cir	ve	1 ☐ Yes 2 🛣	No Specify:			Sp	ecify: Bla	ck	
21215-0036	72 hc	Completed	15. Decede	nt's Education est grade completed)		cedent's Usual Occ ve kind of work do		t of works	na	16b. Kind	f Business/In	dustry	
2	vithin ne. han	шр	Elementary/Secondary (0-12)	College (	life	. DO NOT use ret	ired)	C PPONN	,,g				
7	Hygie Hygie ther t		12 17. Father's Name (First, Middle	l acti		Beautio		r'a Nama	(First, Middle,		emplo	yed	
and	ould be filled within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-1 show atto event, the Medical Examinar most be notified at	Be c	Elijah Bailey	, Last/					Kellan	Maiden Sui	name)		
Maryland	E E E	To	19a. Informant's Name/Relation	ship (Type, Print)	19b. Ma	illing Address (Stre				r City or To	wn State Zin	Codel	
	1 and 2 s Health ar tam 27 is		Mildred D. Hoo	ner / Dau	Service.	Koko Lai					212		
Je,	s 1 a of Hei itam itam		20a. Method of Disposition	•	20b. Place of Dis	position (Name of rematory or other p			72006		on - City or To		
Ē	Page nent c ant: If ury or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (		State	norial Pk				Baltin	nore, N	Marvla	nd
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other ance.		21. Cionature of Funeral Service	License		22. Name and Add	dress of Facility	y The	Derric	k C	Jones	F/H, P	.A.
<u> </u>	207 2 2	J.S. 1)	- W	Tick		611 Park					Maryl.	and 21	.216
	n.		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that t only one cause on a	aused the death. Do not each line.	enter the mode of d	lying, such as o	cardiac o	r respiratory ar	rest,		Approximat Interval Bet	ween
ing .	Physician		Immediate Cause (Final disease or condition resulting in death)	a	1007	@ AM	SKE	NE	_			Onset and I	Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequence of):	0000	. 441	INST	FARC	TIME	)		
1		-	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequence of):	ARU	المرا	1101	ice	V			
W	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	,								
,	exec an an rial-tra		resulting in death) Last	C. Due to	(or as a consequence of):								
8760, 🗽	The law requires that the death certificate be executed at the bes been signed by the ettending physician and page 2 should be detached for use as the burial-transit	dlcai		d		Sie							
Ö	ing pt	0	IF FEMALE:										
Вох	that the death certificed by the ettending posterior detached for use as	Iclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live b		B □Ectopic pregnar				23d.	Date of delive Month	*	Year
0	the e	yslc	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregn 9☐Unkno		☐ Other (specify)					i i i i i i i i i i i i i i i i i i i	Day	i oai
٥.	res that ti igned by be detac	by Phys	Part II. Other significant conditi	ons contributing to de	eath but not resulting in the	underlying cause	given in Part I.		23e. Did to	bacco use c	ontribute to th	e cause of d	death?
Records,	uires n sign ld be	q p		PAD					1 □ Y	es 200	3 ☐ Prob	abły 4 □t	Jnknown
<del>ဂ</del>	w require s been sig	lete		· · · · · · ·					24a. Was a	ın 24	b. Were auto	nsv findings	available
	The lay te hes age 2	Completed							autop: perfor	sy med?	b. Were auto prior to cor death?	1	ause of
Vita		0	25. Was case referred to medica	al			26. Place	of Death	(Check only or	2000	1 🗆 Yes	No.	
	Physic this ce al direc	ToB	examiner? 1 ☐ Yes 2	Hospital: 1 □ I	Inpatient 2 ER/Outpat	ent 3 DOA			ne 5□Resid		Other (Specify	()	
Division of	ng Ph (fter th		27. Manner of Death 1 ZNatural 5 ☐ Pendi	28a. Date of (Mont	of Injury 28b. Time th, Day Year) Injury				8d. Describe h				
<u>S</u>	Attendi death. ctor: A y the fu	catl		igation not be			Yes 2 N						
$\leq$	after of Direct I in by	Certification:	4 ☐ Homicide deterr	nined   200. Place	of Injury - At home, farm, ng, etc. (Specify)	street, factory, offic	θ	2	28f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	l Route Num	iber,
_	ours and maral		29a. Certifier Certifyi	ng Physician: To the	post of my knowledge, de	ath occurred at the	time data and	t place a	and due to the e	auco(c) and	monnos oo ot	atad	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical one)	Examiner: On the bi	sis of examination and/or her stated.	investigation, in my	opinion, death	h occurre	ed at the time, d	ate and place	e, and due to	the cause(s	;)
	To the Hospital or Attending I within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	Me	29b. Signature and title of certifie	er (	41-	29c. Lice	nse number		2	9d Patersig	ned (Month,	Dey Year)	
}	^		> IV WX C	dnit	V L	7	0220	TIN	1- 8	4/	15-6	20	
	15	ŀ	30. Name and address of person	who completed daus	e of death (Item 23a) (Typ	e, Print) / NCN	Al BROC	KING	SON	4	>1	7. ~	10
			AIN HE	11120	1008500	ONC +	100		1901	TOS	b	ノーン	45
	Sta		31. Date filed (Month, Day, Year	V V	esperar's Signature	M > C	7 (00				21-		

			Registrar			State	fManyla	and (Dep Ce	artmen rtificat	t of H e of L	leaith a Death	and M	lental H	ygier Reg. t	1e2006	30	480
	Physici /Medic		Decedent's Name     Cons	e (First, Middl Stance A		œy							2. Date of D Month SEP		ay Year	3. Time (	
	Examir			ærsity :	Specia		spital		Balt	imare					Baltimore	4	
	Funeral Director		5. Social Security N 212–40–3455 Usual Residence of	5	6. Sex	M 2 □ <b>*</b>	7. Age (In yi	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, E 09/25/2	int <b>L</b> Z / Pay, Yea 1996	01/1939 Mary	thplace (State ountry)	or Foreign
	laryland ehow		10a. State	10b. County			10c.	City, Town or Lo	ocation							10d. Inside 0	•
	Ba-fe	Funeral Director	Maryland	Baltim	are		Bal	timare						·		1 🗆 Yes	s 2 🗐 No
	with th	Pre	10e. Street and Nur		1 2				10f. Zip						Citizen of What C	•	
	eath ns 23	eral	11. Marital Status	2 New Yo			edent Ever in	U.S. 13.	2122 Was Decer		ispanic Ori	igin? (So	cify Yes or N		ted States		
920	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural", or Itams 23a or 28a-f ehow any injury or other treumetic event. The Modical Examinet is until by notified at Once.	ğ	1 Never Marri 3 Widowed		ried	Armed For 1 Yes If Yes, Given Year or D	orces? 2. <b>⊠</b> No ve		If Yes, spec 1 ☐ Yes	cify Cuba	n, Mexicar	n, Puerto	Rican, etc.)		Black, Wh	te, etc.	
21215-0036	thin 72 hc e. en "natu	Completed	(Spec	15. Deceden ify only highe ndary (0-12)	it's Educa st grade	ation completed) College (	1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired	during mos !)	t of worki	ing	16b.	Kind of Business	/Industry	
	lad wi lygien her th it, the				14)		<u> </u>	Stock	Contro	l Cle			(m)		tail		
Maryland	ould be fil Mental H arked otl etic even	To Be	Char	les A. C	Iracey	-5								e, Maide	en Sumame)		
Mar	d 2 shi th and 7 ie m treum				ship <i>(Type</i>	e, Print)		230								Zip Code)	
	ages 1 and of Healing 1: If item 2 or other		1 XBurial 2	Cremation		moval from	State _	Place of Dispo cemetery, cre	sition (Nar matory or o	ne of ther plac	e)	C	ate	20c.	Location - City o		
Baltimore,	permit. Pa Departmer Importent any injury		17. Father's Name (First, Middle, Last) Charles A. Tracey  19a. Informant's Name/Relationship (Type, Print) Donna E. Yatkin  296 Esquire Drive, Manchester, Conneticut 06042  20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery) 20c. Location - City or Town State 21. Sate of Parkton, Maryland 20c. Location - City or Town State 21. Sate of Parkton, Maryland 20c. Location - City or Town State 22. Name and Address of Facility Hubbard Fureral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											•			
	40389		23a Part1 Enter th	he disease of	complies	ations that	raused the de					·			Approximate		
	Physician /Medical		shock, or hea Immediate Cause ( disease or condition resulting in death)	rt failure. List Final	only one	cause on e	each line.	epHc	show	±00	9, 00011 00		- Toopiiatory	417031,		Interval Be Onset and	tween Death
Г	Examiner				1	Due to	(or as a cons	equence or):	Dec	ubi	tus	ule	245			4 mon	HSr
<b>.</b>	uted d ansit	Examiner	Sequentially list colif any, leading to imcause. Enter Unde Cause (Disease or that initiated events	nditions, imediate irlying injury	₹	Due to	(or as a cons	equence of):	ohesity							10 42	•
8760,	cate be exacuted physician and the burial-transit	dlcal Exa	resulting in death) I	ast	d.	Due to		equence of):	res	m	ellit	45				1)	_
O. Box 6	he death certiff the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months? ☑No	230	1 Live t	tcome of preg birth 2  Fe nant at time o own	etal death 3	Ectopic pr Other (sp						23d. Date of de Month		Year
Д	w requires that the been signed by should be detac	by	Part II. Other signif	icant condition		_	eath but not r	esulting in the u	nderlying c	ause give	en in Part I				use contribute t		death?
Il Records,	icien: The law requ certificate has been ector, page 2 shoule	Completed											24a. Wa: auto perf 1 □ Yes	s an psy ormed?	prior to death?	utopsy findings completion of a	available cause of
Vital	25. Was case referred to medical examiner?  1								(Check only	one)							
of	Phys this ral dii	tion; To	1 Yes 2 2 27. Manner of Death 1 Deathral		ng	112	Inpatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injury Work	at at	2	me 5 Res 28d. Describe		6 □Other (Specurred	cify)	
Division	or Attendi after daath. Director: A	Certification:	2  Accident 3  Suicide 4  Homicide	6 Could determ	not be	28e. Place build	of Injury - At ing, etc. (Spe	home, farm, str cify)				-	28f. Location City or To	(Street a	and Number or R te)	ural Route Nun	nber,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical C	29a. Certifier (Check only one)	1 Certifyir 2 Medical	Examine	r: On the b and man	asis of exami ner stated.	nation and/or in	vestigation,	in my op	inion, dea	th occurre	ed at the time	, date a	s) and manner a nd place, and du	to the cause(	s)
	To th withir To th comp	Me	29b. Signature and	title of certifie	-				290	. License	number			29d. D	ate signed (Mon.	h, Day, Year)	
•	_			J		0	KNESI	1-1m		<b>D</b> 3	3040	4		C	1125/20	106	
	10			SAIM	who com	spleted caus	se of death (II	em 23a) (Type, South C	Print)	100	st	Bal.	Hmare	- n	Pate signed (Mon 11セミノシロ ルロ 以1セ	30	
	Sta Registi		31. Date filed (Mon	EP 2 6	2006	32,	Registrar's Sig	nature	est.								

Jackey

Constance

			1- State of Mary Registrar	c859,09	artment of l 1/26/06dhb ertificate of	lealth and <i>Death</i>	Mental Hyg	giene 20	06 30481
			Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	Physici /Medi		Joseph Tr	oyer ,	Jr.		Sept.	22, 200	
ķ	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of De	ath	4c. County of	Death
			Sinai Hospital			more Ci			
	Funeral Director		220 - 03 -3414 <sup>1</sup> ⊠M <sup>2</sup> □F 8	yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 H		Year)	N. Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent           10a. State         10b. County         10	c. City, Town or	Location				10d. Inside City Limits
	Mary	ō	MD Baltimore	C	rrinas Mi	11_			1 ☐ Yes 2 🛣 No
	1he	Director	10e. Street and Number		Wings Mi	118	1	Og. Citizen of Wh	at Country?
	3a ol	<u></u>	118 Pleasant Hill		21	117		U.S.	Δ
	death	Funeral	11. Marital Status 12. Was Decedent Eve	r in U.S. 13	3. Was Decedent of H		(Specify Yes or No-	14. Race -	American Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28e-1 show with jujury or other traumatic event, the Modical Examinational be notified at ance.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ West 2 ☐ No If Yes 2 ☐ No If Yes, Give Year or Dates:	ww II	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Pue Specify:	erto Rican, etc.)	Specify:	White, etc. White
Õ	2 ho	Completed	15. Decedent's Education	16a. Dec	edent's Usual Occup	ation		16b. Kind of Busin	
215	hin 7	eg.	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life.	re kind of work done DO NOT use retired	during most of w	rorking		
2	od wil	5	12		Electri	cian		E1	lectrical
p	al Hy al Hy 1 oth	Be (	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle,	Maiden Sumame)	
<u>yla</u>	Ment Ment arkec	2	Joseph Troyer, Sr.			Bes	ssie	Mito	he11
ar	2 sho and and te m		19a. Informant's Name/Relationship (Type, Print)	1	iling Address (Street				ate, Zip Code)
	s 1 and 2 of Health item 27 I		Susan T. Wright Daughter		ark Lane	Reister			21136
ore	if ite		20a. Method of Disposition 2 1 ★ Burial 2 □ Cremation 3 □ Removal from State	Ob. Place of Disposition of Completery, cr	position (Name of rematory or other place	ce)	Date	20c. Location - Ci	ty or Town, State
Baltimore,	Pag ment tant: jury o		4 □Donation 5 □Other (Specify)		Evan. Lut				, Maryland
3aH	Departition Depart		21. Signature of Funeral Service Licensee		22. Name and Addre				
_	₫Q = e d		Sand June		LINE FUNE				D 21136
		1	<ol> <li>Part1. Enter the disease, or complications that caused the hock, or heart failure. List only one cause on each line.</li> </ol>	death. Do not e	nter the mode of dyin	ig, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final	d Abd	anutel	Acontic	ANCLEY	Sin	Onset and Death
	/Medical Examiner		Due to (or as a co	onsequence of):		8			
	LAGITITICI	L			hc (1/20	icucia	cion Dine	EVE.	
	ed sit	lner	if any, leading to immediate Due to (or as a co cause. Enter Underlying Cause (Disease or injury	insequence of):					
	and and I-tran	Examin	that initiated events resulting in death) Last  Due to (or as a co	nsequence of):					
8760,	cate be executed physician and the burial-transit	ᄪ							
	phys the	dlcal	d						
9 X	The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of p	regnancy				23d. Date of	of delivery
Box	atter atter	clar	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)			Month	
o.	the d y the	ys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		_ = = = = = = = = = = = = = = = = = = =				
Ω.	that ned b	y P	Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
ds.	sign of be	d by	Chrone Brevelens	1001	Allows Use	Muci	1 🗆 Y	es 2, No 3	☐ Probably 4 ☐Unknown
Ö	w require been si should t	lete	Pauphona Vouces Decay				24a. Was a	n 24h We	re autopsy findings available
Re	hysician: The law his certificete has t I director, page 2 s	Completed		2 <u> </u>	(augnor	11	autops perfora	med? prio	or to completion of cause of the
la	ifficet or. pë	e C	25. Was case referred to medical			OS Diago of D			Yes 2 No
5	Physician: this certificantal director, participations	To B	examiner?	2 ER/Outpatio	ent 3 DOA Oth	<b>AC</b>	eath Check only on Home 5 Reside		Canada Street Hospital
Division of Vital Records,	O - 0	n: T	27. Manner of Death 28a. Date of Injury	28b. Time	of 28c. Injun			ow injury occurred	(Зреспу)
<u>0</u>	Attending I or death. ector: Atter by the funer	atlo	1 ☑Natural 5 ☐ Pending (Month, Day Ye 2 ☐ Accident investigation	ar) Injury		k? Yes 2 □ No			
Vis	Attendi ar death. ector: A by the fu	ill C	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (5	At home, farm, s	street, factory, office				or Rural Route Number,
Ō	s afte	Certification:	Dullarity, etc. (3	рөспу)			City or Town	i, State)	
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer		29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner: On the basis of examiner.	y knowledge, dea	ath occurred at the tin	ne, date and pla	ce, and due to the co	ause(s) and mann	er as stated.
	the H in 24 the F	Medical	and manner stated.	annation and of			Curred at the time, d	ate and place, and	due to the cause(s)
	To To com	2	29b. Signature and title of certifier	ki e .	29c. License	e number	2	9d. Date signed (/	
,			MANY A M	C Lv	) 1025	200		4/25/04	<b>3</b> ·
1	.41		30. Name and a viress of person who completed cause of death						2 .
	eT		GHOLY H MATERO MA) 3)	O METTY	N STREET,	12EIST	CRETCUL,	ing can	26
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's SEP 2 6 2006	Signature	D.				
36	Registr	ar	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	A STATE OF THE PARTY OF THE PAR					

			For State	State of Maryland	-	rtment of F			giene leg. No	2006	301.82
8	Physici		1. Decedent's Name (First, Middle, Last, Bobbie 1.11)	nn Tesh		inouto or i	D Guill	2. Date of Dea Month		2 Year	3. Time of Death 8:38 AM
100	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Balt	r Location of Deal			County of Death	
	Funeral Director			7. Age (In yrs. lasi	t birthday) _ Yrs.	If Under 1 Year Months Days	Hours Min.		Year)	9. Birth	placeBarrerring r y Land
	Maryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  Md. Balti		Town or Loc						10d. Inside City Limits 1 ☐ Yes 2天 No
	or 28a-	Funeral Director	10e. Street and Number			10f. Zip Code			log. Citiz	en of What Cou	ntry?
	a 23a	erai [	8180 Del Haven		140.14		222	2		USA	
980	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than *naturel', or items 23a or 28a-f ehow importants if item 27 is marked other than *naturel', or items 23a or 28a-f ehow yill injury or other traumatic event, it is Mudical Examinar must be multilled at ance.	by	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	Specify:	Specify Yes or No- to Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh	etc.
1215-0036	vithin 72 ho	Completed	15. Decedent's Edu (Specity only highest grad Elementary/Secondary (0-12)		(Give F life. D	ent's Usual Occup kind of work done of O NOT use retired	ation during most of wo	erking	16b. Kin	d of Business/In	dustry
d 21	filed with Hygiene. other than		n / a 17. Father's Name (First, Middle, Last)			n/a	18. Mother's Na	me (First, Middle,	Maiden S	n/a Sumame)	
ılan	should be tind Mental I	To Be	William Lee	Tesh			Steph	anie A	nn	Chearr	10
Maryland	12 sho h and i 7 Is mu		19a. Informant's Name/Relationship (Ty William & Steph					Baltim			
	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. Plac		ition (Name of atory or other place				ation - City or To	
Baltimore,	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)					6-06	Bal:	cimore	, Maryland
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens  Tolut July	lan	12	01 Dund	lalk Av	e. Balt	imoı		Home, PA 21222
€	Dhysisian		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		•		c or respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen	nce ol):		•				
E,	Examiner	P	Sequentially list conditions, if any leading to immediate	Due to (or as a consequent		orioar	nnuoni	.Pas			
•	death certificate be executed e attending physician and nd for use as the buriat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen					_		
3760	ate be e nysiciar he burii	Icai	L.	1.							
89 X	certifica Iding ph	/Med	IF FEMALE:	3c. If yes, outcome of pregnancy	v				2	3d. Date of delive	
.O. Box	D 0 D	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)			2.	Month	Day Year
rds, P.	Physician: The law requires that the this certificate has been signed by the fall director, page 2 should be detached.	٥	Part II. Other significant conditions con	ntributing to death but not resultin	ng in the un	derlying cause give	en in Part I.		baccous es 2.0≸		he cause of death?
l Records,	The law re ate has be page 2 shi	Completed						24a. Was a autops perform	SV	death?	ipsy lindings available impletion of cause of
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	lospital:		104		ath (Check only or	10)		
		tion: To	1 Yes 2 No   27. Manner ol Death  1 Natural 5 Pending 2 Accident investigation	1 X Inpatient 2 LER	VOutpatient Bb. Time of Injury	28c. Injun World	4 🗆 Nursing F	10me 5 Residence 28d. Describe he			(y)
Division	I or Attendi atter death. I Director: A d in by the tu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and n, State)	Number or Rura	il Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely tilled in by the tune	edicai C	29a. Certifier 12 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the timestigation, in my of	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) a ate and p	and manner as s place, and due to	tated. the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	20 110		29c. License		2	9d. Date	signed (Month,	Day, Year)
			30. Name and address of person who co	mpleted cause of death (Item 23	3a) (Tuno 5	KES-	-0000		09	124/2	000
			Jehnifer P. To	aulor MD	301	St. Pau	u Place	Baltin	iore	MD 2	21202
0.00	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 6 2006	37/Registrar's Signature	Loc	de					

State of Maryland / Department of Health and Mental Hygiene 200630483 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Joseph Vigna, Jr. <u> 11:10 A M</u> Sept 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 506 Trimble Road Joppa If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F Yrs Director 83 6-8-1923 PA 216-16-1585 Usual Residence of Decedent with the Maryland or 28a-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No MD Harford Joppa Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 21085 USA death v 506 Trimble Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married TYPES 2 WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene.
Item 27 Is marked other than
other treumatic event, the M Fireman Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louisa Marazzo Joseph Vigna, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Trimble Rd., Joppa, MD 21085 Regina Vigna - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or poper. Bayview Crematory 9-25-06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD permit. 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral S PA, 2134 Willow Spring Road, 21222 MO1455 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final intarction Myocardial Physician /Medical resulting in death) Due to (or as a consequence of): Examiner loyears vascular disease peripheral Securatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Diabetes Mellitus the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Exami Type 10 10915 physician and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. 2 weekc mal nutrition Completed by Physician/Medical th e ettending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s autopsy performed? 1 ☐ Yes 2 🗷 No 1 Yes 2 No ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this Director: After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NO September 25, 2006 00058878 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1321 Riverside Parkway Svite A Belcamp MD 21017 Elisabeth Tilleros 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 26

Registrar

2006

06-07144 Please Type or Print in Black Indelible Ink Joanne Valcourt State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Y September 22, 2006 0849 hrs Medical Examiner Joanne Mary Valcourt 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death John Hopkins Bayview Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Foreign Months Days Hours Director Country) MD M 2 x F 59 212-46-6430 0/14/1946Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show any notified at once. 10a. State 10b. County 1 X Yes 2 No Baltimore more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland neart of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 338 S. Oldham St. 21224 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, is marked other than "natural", or items atic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Yes 2 X No specify: White 3 Widowed Divorced If Yes, Give Yeer 1 Yes 2 X No specify. ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Receptionist Hospital 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Joseph Alagna <u>Olga Imperatore</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 19a. Informant's Name/Relationship (Type, Print ) Michael Valcourt, Sr. - husband 338 S. Oldham St. Baltimore, MD 21224 Baltimore, N permit. Pages I and Department of Healtl Important: If item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other place) or other 09/25/2006 Baltimore, 4 Donation 5 Other Specify 0aklawn 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Charles S. Zeiler & Son injury 6224 Eastern Ave. Baltimore, MD 23a. Part I. Ente Jeath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Hypertensive Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and ed for use as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. is been signed t should be deta þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available After this certificate has been 24a Was an prior to completion of cause of autopsy death? performed? Yes 2 V No 2 1 Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) director, Be Hospital: Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A 1 Natural Yes 2 No Pending the Investigation Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 22, 2006

ess of person who completed cause of death (Item 23a)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

		í	1 - State Registrar	State of Maryland / De	epartment o Certificate			ene 2006	30485
1,	0 8		Decedent's Name (First, Middle, Las	')			2. Date of Death	1	3. Time of Death
	Physici		Ruth V. WY	c121-			Month	Day Year 24 2006	5.15PM
5	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, To	wn, or Location of Death	1	4c. County of Death	
		9 201	Levien Nursi	1	(	viumb(c		Howa	and
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birth	day) If Under 1		8. Date of Birth	9. Birth	place (State or Foreign
	Director		721-12-3328	IM 2007 97 YI	rs. Months D	ays Hours Min.	(Month, Day, 12 - 21	-/3	CT
	밀		Usual Residence of Decedent						
	how	_	10a. State 10b. County	10c. City, Town		h . A			10d. Inside City Limits
	Ba-f e	cto	MD Howa	md 130	Intonsi	ville			1 □ Yes 2 ☑ No
	or 24	Director	10e. Street and Number	, 0 -	10f. Zip Co	ode	10	g. Citizen of What Cou	intry?
	death with the Maryland ims 23e or 28e-f ehow r must be notified at	ia	3704 Ams	sterdam Terra	ice 2	0866		USK	7
	SE SE SE SE SE SE SE SE SE SE SE SE SE S	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol><li>Was Decedent If Yes, specify</li></ol>	t ol Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White	
36	or It	by Fu	1 Never Married 2 Married	1 Ves 2 No II Yes, Give	1 □ Yes 2 🗹	No Specity:		Specify: A	1.10
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or litems 23a or 28a-f show other than "natural", or litems 23a or 28a-f show avent, the Madical Examiner must be natified at		3 ☐ Widowed 4 ☑ ivorced	Year or Dates: 1945-47				0	rach
5	"nat	Completed	15. Decedent's Ed (Specify only highest grad	ie completed) (	Decedent's Usual C Give kind of work o life. DO NOT use i	done during most of wor	king	6b. Kind of Business/li	ndustry
2	within 606 than ne Mag	ם	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		eacher.		1100	~ 1
	e filed within al Hygiene. other than 'vent, Ine Ma		17. Father's Name (First, Middle, Last)		1/626		ne (First, Middle, M	laiden Sumame)	Cap
ano	ntal l	Be	Total	MCCau					A
Ž	should by nd Menta marked matic ev	ဥ	19a. Informant's Name/Relationship (7	ivos Print) 19h I	Mailing Address (S	treet and Number or Ru		City or Town State 7	
Maryland	ges 1 and 2 should it of Heelth and Mer if Item 27 is marke or other treumatic		- 1 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
-	1 an Heel em 2 ether		20a. Method of Disposition	20b. Place of E	Disposition (Name	of .	Date 2	Oc. Location - City or T	CORN FL33907 own, State
و	Pages nent of int: If It iry or o		1 Surial 2 ☐ Cremation 3 ☐	Removal from State cemetery,	crematory or othe	r place)	,		( Sa )
Baltimore	rtmert rtant njury		4 □ Donation 5 □ Other (Specify 21. Signature of Fun ral Fervice Fcen			em (em 9/2		-arming d	ave, N.Y.
Ba	permit. Pag Department Important: I any injury o		21. Signature of Pull-fail Delivice Cells		Hari	Address of Facility Piclose Belain	Funera	1 Service	e P.A.
. *			23a. Part1. Enter the disease, or comp shock, or heart failure. List only		t enter the mode o	f dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
1	Physician		Immediate Cause (Final	a. Due to (or as a consequence of	A. Sticile	Collitis	Leads &	a	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence of	11000		9	(	
	Examiner			to Lader	to	thripe .			
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a consequence of	):				
B.	uted d ansit	Examiner	Cause (Diseese or injury that initiated events	0					
, (	be executed icien and burial-transit	Еха	resulting in death) Last	Due to (or as a consequence of	):				
8760,	ate be executed hysicien and the burial-transit	dicai		d					
9	the death certificate y the ettending phys iched for use as the	ed							
Вох	eath certific ettending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	2 Totalia			23d. Date of deliv	rery
œ.	deatl	lcia	in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnant at time of death	3 ☐ Ectopic pregr 5 ☐ Other (speci			Month	Day Year
P.O.	that the de ed by the detached	hys	9 🗆 Unknown	9 Unknown					
ď.	The law requires that ate has been signed b bage 2 should be deta	by P	Part II. Other significant conditions co	ntributing to death but not resulting in t	he underlying caus	se given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Ë	w require been sig should b	ed					1 🗆 Yes	s 2 No 3 Pro	bably 4 Junknown
00	s been s been 2 shoul	piet					24a. Was an		opsy findings available
æ	The law ate has page 2:	Completed					autopsy perform	ed2 death?	ompletion of cause of
ta		0	25. Was case referred to medical			26. Place of Dea	th (Check only one		
<u>&gt;</u>	8 w D	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2   ER/Outp	eatient 3 DOA			nce 6 Other (Speci	fv)
0			27. Manner ol Death	28a. Date of Injury 28b. Tir		Injury at Work?	28d. Describe how		-97
<u>ö</u>	nding Path. r: After e funera	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day Year)	ury M	1 Yes 2 No			
Division of Vital Records,	of or Attending after deeth. Director: After d in by the fune	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, lactory, o	ffice	281. Location (Stre City or Town,	eet and Number or Rui	al Route Number,
Ö	el or s afte al Dir	Certification:	4 - Hornoldo	building, etc. (Specify)			City of Town,	State)	
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	dicai	29a. Certifier 1 V Certifying Phy	vsician: To the best of my knowledge, iner: On the basis of examination and					
	the Hin 24 the F	a	one)	and manner stated.	ar in congulation, in	my opinion, obali occu		te and place, and oue	o me cause(s)
	To To	Σ	29b. Signature and title of certifier	0	29c. L	icense number	29	<ul> <li>d. Date signed (Month)</li> </ul>	Day, Year)
•			Laim M		12	00035101		9/25/	υ 6
	0		30. Name and address of person who o	ompleted cause of death (Item 23a) (T	ype, Print)	CEC.	-	(97)	
			KAJ CHAWLA	14300 Galland	tux 1	me SIE #	210 Be	wie MD	20710
	Sta Registr		31. Date filed (Month, Day, Year) 6 2	and manner stated.  ompleted cause of death (Item 23a) (T 143 ov Calland  32. Registrar's Signature	Goarles				

		1 - For State Registrar	State of Maryla	and / De	partment of Certificate o	Health	and Mental H	ygiene Reg. No	2008	30486
Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Dean Paul Witt, S  4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town	Utim	of Death UNE	Day 18EK & 4c.	Year 1) 2006 County of Dea n/a	
Funeral Director		5. Social Security Number 6. Sex 214-64-5880 1 X	M 2□ F 7. Age (In yr		Months   Day		Min. 8. Date of the Mar. Mar.	3irth Day, Year) <b>7,</b> 19	Co	thplace (State or Foreign ountry) ryland
ie Maryland Be-f show	ctor	Md. Baltim		City, Town o	_					10d. Inside City Limits 1 ☐ Yes 2X No
h with th	al Dire	10e. Street and Number 4713 Ruby Avenue			10f. Zip Code 21 2	227		10g. Citi	izen of What Co USA	ountry?
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examinational than notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2[XMarried 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S.	I3. Was Decedent of If Yes, specify Cu		rigin? (Specify Yes or in, Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:	
within 72 ho ane. than "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(G lif	ecedent's Usual Occ ive kind of work dor le. DO NOT use reti	ne durina mo.	st of working	16b. K	ind of Business	
uld be filed Aental Hygir rked other tic event, L	To Be Co	17. Father's Name (First, Middle, Last)  Clayton Witt	0	Cal	rpenter		er's Name (First, Midd herine M.			
end 2 shore ealth and hm 27 is manner trauma		19a. Informant's Name/Relationship (Ty) Shirley Jean Witt	/ wife	4713	3 Ruby Ave	enue,	ner or Rural Route Num Wynnewood,	Mary	land 21	227
Pages 1 nent of H ant: If ite ary or otl		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □R. 4 □ Donation 5 □ Other (Specify)			sposition (Name of crematory or other p idge Mem.		Date 9/25/06		cation - City or Cidge, N	Town, State Maryland
permit. Departr Importa		21. Skin ture of Funeral Service Dicense			22. Name and Add		11 about a			, Inc. yland 21229
Physician /Medical Examiner	En i	23a. Parri. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the dee cause on each fine.  MYOCM  Due to (or as a cons	RDIN	enter the mode of d	ying, such as	s cardiac or respiratory			Approximate Interval Between Onset and Death
ate be executed y sysicien and he burial-transit	Examiner									
to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours efter death. In the continuate to the Funerel Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death	3 □Ectopic pregnar 5 □ Other (specify)				23d. Date of del Month	livery Day Year
w requires that been signed t should be det	ρ	Part II. Other significant conditions con			e undertying cause of					the cause of death?
: The law requirete has been page 2 should	Completed						24a. We au pe	topsy rformed2	prior to death?	utopsy findings available completion of cause of 2 No
ding Physician: Th h. After this certificate funeral director, pag	n: To Be	27. Manner of Death	ospitaf: 1 ☐ Inpatient 2.  28a. Date of Injury (Month, Day Year)	ER/Outpa 28b. Time Injur	e of 28c. In	Other: 4   N	e of Death Check only ursing Home 5 Re 28d. Describ	sidence (		cify)
To the Hospital or Attendin within 24 hours effer death. To the Funerel Director: All completely filled in by the fur	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm,		☐Yes 2☐	28t. Location	(Street an own, State	d Number or Ru )	ural Route Number,
Hospita     24 hours     Funerel letely filler	edical C	29a. Certifier 1 Check only one) 1 Madical Exemin	ician: To the best of my ker: On the basis of exami and manner stated.	nowledge, de nation and/o	eath occurred at the r investigation, in my	time, date ai y opinion, dea	nd place, and due to the	e cause(s) e, date and	and manner as place, and due	s stated. e to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	m		29c. Lice	nse number	865	29d. Dat	e signed (Mont	n, Day, Year) n 21, 2006 mb
20		30. Name and address of person who con  LIMPLUS  31. Date filed (Month, Day, Year)		TAG	oe, Print) NES HO	150119	n BAL	MM	ORE	ms
Sta Registr		SEP 2 6 20	16 1 200 200 3	13.	GORALI					

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Amend Items 10a-f, 19a builder By July gs 1- For State Reg No Registrar . Decedent's Name (First, Middle,Last) Date of Death Physician/ Day 24 Month Year Wilford J. Welsh Medical Examiner 1208 hrs September 23, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 8733 Pulaski Highway RM #35 Rosedale **Baltimore County** 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** 242-24-7092 Months Days Hours Director 90 Country) Texas 1 XM March31,191 Usual Residence of Decedent 10a. State VA 10b. County 10c. City, Town or Location 10d Inside City Limits Accomack MD Essex Horntown Yes 2 X No 28a-f show hours after death with the Maryland Director 10e. Street and Number 10g Citizen of What Country? 10f. Zip Code 604 Pintail Drive 23395 23a or 2 <del>Riverside</del> 21221 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian, Black, items ist be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 White etc. Married 2 X No Yes 3 XWidowed Divorced If Yes, Give Year Yes 2 X No specify: Specify. White iner \$ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Complet ment of Health and Mental Hygiene tant: If iten 27 is marked other than or other traumatic event, the Medical Shipyard Planner Baltimore, MD 21215-0036 Beth Steel 10th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William L. Welsh Be Effie Johnson 19a **Gloria Campbell Daughter** Wilford J-Welsh /son ဥ 9b Mailing Address (Street and Number of Rural Route, Number City of Town, State, Zip Code) **209 Briarcliffe Lane, Bel Air, MD 21014**404 A Riverside Road Baltimore MD 212 <del>-21221</del> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Holly Hill Cemetery 9/27/06 Baltimore MD Department of Important: 4 Donation 5 Other Specify 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licens e Connelly Funeral Home of Essex 21221 Part I, Enter the disease, or o mplications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** failure List only one cause Between Onset and /Medical Death a Contact gunshot wound of head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ian/Medica UNPENDED attending physician or use as the burial AMENDED item#2,perME,g860, 10/3/06 TT requires that the death certificate be Box 68760 IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Physici 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 Yes No 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self FOUND: Natural 5 Pending Yes 2 🗸 No after death. Sep 24, 2006 1205 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide 6 Could not be or Town, State) 8733 Pulaski Highway RM #35, Rosedale, MD 24 hours a determined (Specify) Hotel/Motel Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E September 25, 2006 Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		•	1 - For State Registrar	State of Marylan	-	ent of Health and ate of Death		ene g. No. 200 (	30488
	Physici /Medio	ai	1. Decedent's Name (First, Middle, Last)	a Worthmo			2. Date of Death Month Septembe	Day Year	
	Examir Funeral Director	er	4a. Facility Name (If not institution, give :  VNION MEMOU  5. Social Security Number  212-32-8439	ial Hospita		Baltimore  der 1 Year If Under 24 Hr s Days Hours Min	'S. 8. Date of Birth	Year) C	nthplace (State or Foreign
	ס	ctor	Usual Residence of Decedent  10a. State  10b. County  MARY I GAC  Baltin		y, Town or Location		Jany 10		10d. Inside City Limits 1 □Yes 2 XNo
	death with the Maryland ime 23a or 28a-f ehow rmus Les collified at	rai Director		Avenue		21234		g. Citizen of What C	A .
9000	d within 72 hours after death with the Marylan jene: rrthen "naturet", or iteme 23a or 28a-1 ehow tte Medical Evandinet maal be notified al	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ★Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	ed within 72 h ygiene. her then "natu it, itte Medica	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0·12)		16a. Decedent's U (Give kind of life, DO NO	work done during most of w Fuse retired)	orking 1	6b. Kind of Business BP Amol	2 1
Maryland	be fill H	To Be (	17. Father's Name (First, Middle, Last)  George U  19a. Informant's Name/Relationship (Ty	lorth man	19h Mailing Addr	18. Mother's N		affin	Zin Code)
	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic		John Bachyns  20a. Method of Disposition  1 Burial 2 Cremation 3 DR	Ki-Spouse 200. P	7704	Wilson Av	enue Par	CKVILLE S	MO 21234 Town, State
Baltimore	permit. Pag Depertment Important: any injury o		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License  attrocolourum	30 actor tom	22. Name	and Address of Facility  The form of the control of	chapel - 6	Forest Belair Macylano	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.		ode of dying, such as cardi			Approximate Interval Between Onset and Death
,		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	y art	e eny dise	asl		3 weeks
68760,	death certificate be executed e attending physician and bd for use as the burial-transit	Ical	L.	hyperte	nsion				15 yrs
P.O. Box	that the death certific ed by the attending p detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3 ☐ Ectopic			23d. Date of de Month	livery Day Year
	n requires that the been signed by th should be detache	þ	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the underlyin	g cause given in Part I.			o the cause of death?
e se se se se se se se se se se se se se									
Division of Vir	<u>a</u> = <u>a</u>	ce 6 Other (Spe	ocify)						
Divis	in the second	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	<i>(</i> )		City or Town,		
2	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	202 Cnifier 1 Cert ying Physical Examinates (Check only one) 2 Medical Examinates Medical Examinates (Check only one) 29b. Signature and title of certifier	ner: On the bast of my kno- ner: On the basis of examinal and manner stated.	tion and/or investigat	on, in my opinion, death occurred place on the my opinion, death occurred by the my opinion of the my	curred at the time, dat	e and place, and du	e to the cause(s)
)	b $\lambda$	1	and title of certifier  and title of certifier  and title of certifier  and address of person who co		do	AT243894		the Date signed (Monitorial Monitorial ,2006 Typkwy	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ninemo	ial hospite	BC	Trimose,	mp alals

			1 - For State Registrar	State of Mar	ryland / Depa <i>Cel</i>	artmen <i>rtificat</i>			nd Me		giene Reg. No.2	200	6	304	8 9
	Physici /Medi		Decedent's Name (First, Middle, Las     HELEN MARIE	•						2. Date of De Septe		22,2	<b>3</b> 06	3. Time of De. 3:30 A	
	Examir		4a. Facility Name (If not institution, give 119 Locust Dri	ve		(	Cato	Location of nsvi	lle		1	ounty of D Balt		re	
	Funeral Director		5. Social Security Number 6. Security Number 212-20-0037	ex □M 2∏ F	(In yrs. last birthday) 82 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	B. Date of Bir Month, Da August	<sup>th</sup> <sup>Y</sup> 20, 1	924	Birthpla Country Mar	ce (State or Fo yland	reign
	Maryland	tor	10a. State 10b. County	ltimore	10c. City, Town or Lo	cation	le						100	d. Inside City L	
	th with the	ai Direc	10e. Street and Number 3317 Woodside	Avenue		10f. Zip		1234			10g. Citize	n of What		y?	
920	within 72 hours after death with the Maryland ene. than "natural" or iteme 23a or 28a-1 show ta Madical Examinar must be recitied at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates:	)	Was Deced If Yes, spec 1 ☐ Yes	-	spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)	į.	. Race · A Black, V pecify:	/hite, et		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or iteme 23a or 28a-f show with injury or other traumatic event, the Medical Examinational Lancitied at ance.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		dent's Usua kind of wo DO NOT us Sales	rk done di se retired)	tion uring most	of workin	9	16b. Kind	of Busine		•	
Maryland 2	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Reginaldo Tor	massi						First, Middle, a Pet					
	and 2 sho ealth and I m 27 Is ma		19a. Informant's Name/Relationship (T Karen Zink Brow		er 119	Locu	ıst 1	nd Number Drive	e-Ca	Route Numbe tonsvi	or, City or T lle, Ma	own, Stat aryla	e, Zip C and	ode) 21228	
Baltimore,	thent of H tent: If Its		20a. Method of Disposition  1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify)	)	20b. Place of Dispo cemetery, cren Parkwood	Ceme	ther place tery		Da -26-		Park	-		n, State Iryland	
Ba	Depar Impor any Irr		21. Signatur f Funeral Service Licens	ME Food	She 88	300 Ha	arfor			NS CHA rkvill		F MEI ylan	MORI 21	ES 234	٠
<i>y</i>	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events	a. Due to (or as a c	Consequence of).							12	- Ir	pproximate nterval Between nset and Deat	th
68760,	rtificate be executed ng physicien and as the burial-transit	dicai	resulting in death) Last	Due to (or as a d	consequence of):										
P.O. Box	es that the death certif gned by the attending be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [ 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pro Other (sp.					230	I. Date of Month	delivery Da	ay Year	
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but r	not resulting in the ur	nderlying ca	ause giver	n in Part I.		23e. Did to				cause of death ly 4 ⊟Unkn	
Division of Vital Records,	The ate h	Completed								24a. Was autop perfor 1 Yes	an 2 sy med? 2.23.No	death	autopsy to comp i? 'es 2[	y findings avail letion of cause ☑ No	able of
<b>\frac{1}{5}</b>	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Tyes 2 🕅 No	Hospital:	• C 5000		Other			Check only o					
ion of	nding Physath. r: After this e funeral di	ı – ,	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Y	28b. Time of		Bc. Injury	at ALJ NUIS	28	d. Describe h			pecify)		
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the funeral Director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	r - At home, farm, stre (Specify)	eet, factory	, office		28	f. Location (S City or Tow	treet and N n, State)	lumber or	Rural R	oute Number,	
	o the Hospital or vithin 24 hours after to the Funeral Dir empletely filled in	Medicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examination)	rsicien: To the best of r iner. On the basis of ex and manner stated	xamination and/or inv	occurred a restigation,	at the time in my opi	e, date and nion, death	place, an occurred	d due to the d at the time, o	ause(s) and date and pla	d manner ace, and c	as state	ed e cause(s)	
)	Tor	Σ	29b. Signature and title of certifier	Jame		29c	License	number	220		9d. Date s	igned (Ma			
	le i		30. Name and address of person who a SIWDHW JAW		th (Item 23a) (Type, I		(C  2	onn	L	u I la in	nlle	. 1	vo .	2109	3
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's		Back									

DHMH 17 Rev 1/2001

30490

	1	D. A. M. Maria (Final Adiatale Anna)	per FH,		Jenincale (	or Death	2. Date of D	Reg. No.		3. Time of Death	
Physician		. Decedent's Name (First, Middle, Last)	aratku	ar V	. Amin		Month	Day	Year	1211 AH	
/Medical		Bharatik Umar V	- /- <del>  14</del>	14/	4h Cihi Tou	n, or Location of D	09		County of Dea	6	
Examiner		a. Facility Name (If not institution, give street and I		1	Balt.		, oatri				
	_	Universify of Maryland 1. Social Security Númber 6. Sex	7. Age (In y	rs. /ast birth				irth	Baltin 9. Bi	nore City rthplace (State of Foreign	
Funeral Director		730-05-5454 18M 20F			Months Da	ys Hours M	Vin. (Month, D	10, 195	1	India	
	$\vdash$	Jsual Residence of Decedent					June	10,110	•	THOTA	
Mo T	1	0a. State 10b. County	10c.	City, Town	or Location					10d. Inside City Limits	
to r 28a-f show		PA Lackawanna		Scrant	on					1 Yes 2 No	
irec	1	0e. Street and Number			10f. Zip Coo	le .		10g. Citiz	en of What C	ountry?	
23a c		638 Quincy Ave. Apt	. 2			18510			India		
ritams 23a	1	Marital Status     12. Was De Armed	ecedent Ever in Forces?	U.S.	13. Was Decedent If Yes, specify (	of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	lo- 1-	4. Race - Am Black, Wh	erican Indian, ite. etc.	
0 5		1 Never Married 2 Married 1 Ye	s 2 No Give		1 ☐ Yes 2 🗶				Connife		
Exal d by		3 Widowed 4 Divorced Year of	Dates:		, -					Asian/India	
ner than "natural it, the Medical is Completed		15. Decedent's Education (Specify only highest grade complete	d)	(	Decedent's Usual Od Give kind of work do life. DO NOT use re	ne during most of	working	16b. Kin	d of Busines:	s/Industry	
mp mp			(1-4or 5+)	'					Dotai	1 or	
evant, the M evant, the M Be Comp	,	7. Father's Name (First, Middle, Last)			Cler		Name (First, Midd	le. Maiden S	Retai	TET	
ad out	i						alaben	Pate:			
ls markad other than eumatic evant, the Markan To Be Comp		Vitthaldas Amin  19a. Informant's Name/Relationship (Type, Print)		19h /	Mailing Address (Str					Zin Code)	
7 Is 1 treui					38 Quincy				18510	Apt. 2	
item 27 is marks other treumatic	1-2	Hiren Amin Son	208			The second secon	Date	-			
or or	i	1 Burial 2 remation 3 Removal fro	III State		_	1	/1 / /2006				
rient rient rient	1	1 Durial 2 Operation 3 Removal from State 1 Donation 5 Other (Specify)  Cemetery, crematory or other place) Maple Hill Crematory 9/14/2006 Wilkes-Barre, PA									
Department of Health a Importent: If item 27 Is eny injury or other tree			01058			-	Scrantor ome, 343	, PA Madis	18510 <u>on Ave</u>	Lic FD014	
		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause o	at ceused the de	eath. Do no	t enter the mode of	dying, such as car	rdiac or respiratory	arrest,		Approximate Interval Between	
ysician		Immediate Cause (Final disease or condition	st-Carde	otomy	Cordinen	ic Shock				Onset and Death	
Medical	resulting in death)  Due to (or as a consequence of):								73		
aminer	1	Sequentially list conditions b. Recent Cardiac Surgery							6 Days		
ial-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a cons	sequence of	):	1 1.	Λ-				
and trans		that initiated events c	to for as a cons	+ Co	ronary	Hr Ferry	Wisease			1	
		Due	to (or as a cons	equence or	1.	,					
physicials the bu		d									
D 49		IF FEMALE: 23c If yes	outcome of pre	nnancy	· <u> </u>			0.	Id Data of d		
ed by the attending detached for use at Physician/Me		in the past 12 months?	e birth 2 □ F	etal death	3 ☐ Ectopic pregna 5 ☐ Other (specifi			2.	3d. Date of de Month	Day Year	
the shed			known	n death	3 - Other (specin)	7					
signed by be detact		Part II. Other significant conditions contributing to	death but not	resulting in	the underlying cause	given in Part I.	23e. Dio	I tobacco us	e contribute	to the cause of death?	
sign d be		Hypertension Hypero	Wester	levice	1		10	Yes 2 🕽	No 3□F	Probably 4 Unknow	
cate has been signe, page 2 should be d	3	(1)						s an	24h Were a	utopsy findings availab	
has ge 2 mp	-			*			aut	opsy formed?	death?	autopsy findings available completion of cause of	
icate r. pag							1 ☐ Yes		1 □ Ye	s 200-No	
rector	1	25. Was case referred to medical examiner?  Hospital:				Other	Death (Check only				
r this certificate has be and director, page 2 s		TES ZE NO	★Inpatient 2 te of Injury	28b. Ti		4   Nursi	ng Home 5 Re 28d. Describe			ecity)	
After fune flon		1 Natural 5 ☐ Pending (M	onth, Day Year			njury at Work? 1 □ Yes 2 □ No					
rs after death.  al Diractor: After ted in by the funera  Certification;	2	3 Suicide 6 Could not be 200 Pt	ace of Injury - A	t home, farr	n, street, factory, off		28f. Location	(Street and	Number or F	Rural Route Number,	
Dira Dira In b	5	4 Homicide determined bu	ilding, etc. (Sp	ecify)	, , , , , ,		City or T	own, State)			
within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral Medical Certification; 7		29a. Certifier Check only 2 Medical Examiner: On the	a basis of exam	knowledge, ination and	death occurred at the	e time, date and p	place, and due to the	e cause(s) a	and manner a place, and du	as stated.	
the Figure 1			anner stated.		20= 1			20d Data	nigned (Mar	oth Day York	
	1	29b. Signature and title of certifier	M.			ense number				nth, Day, Year)	
To the comp		1) - 2 1h	W /1	シ	AU	4176425	712810	Je P	- 11	2006	
within 2 To the complete											
	,	30. New and address of green who completed co	ause of death (	tem 23a) (1	ype, Print)	6	7 11.			4.	
12 con con		David Deter m	ause of death (	tem 23a) (T	South Gree	ne Sr 1	Bultimere	MD	212	øl	

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar MEDICAL CENTER DR., ROCKVILLE, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 9901

ægistrar's Signature

YAO-YAO ZHU,

31. Date filed (Month SEP Par)2 2006

			1 - For State Registrar	State of I	Marylar				lealth a			Reg. No	ZUUb.	304	92
P.	Physici /Medi		1. Decedent's Name (First, Middle Doris Eliz		Adams	3				S	2. Date of D Month epten		y 11, 20	3. Time of 1:3	
-	Examir		4a. Facility Name (If not institution 907 She1by		er)				r Location o	of Death			County of Deat		
7,461	Funeral Director	==:	5. Social Security Number 248 – 62 – 8454	6. Sex 7. 1 ☐ M 2 ☐ ▼ 7.	Age (In yrs.	last birthday) 6 Yrs.	If Unde Months	r 1 Year Days	Hours	Min.	8. Date of Bi (Month, D	irth (ay, Year) 1.19	Co	hplace (State or untry)	r Foreign
100	aryland show d.at	_	Usual Residence of Decedent  10a. State  10b. County	2		ity, Town or Lo								10d. Inside Cit	•
	r 28a-f	Director	MD Princ  10e. Street and Number	e Georges	0:	xon H		o Code				10g. Cit	tizen of What Co	1 🗆 Yes	2 <u>A</u> No
	23a o		907 Shelby D	rive				207	745				USA		
920	be filed within 72 hours after death with the Maryland hal hygiene. Id other than "natural", or Iteme 23e or 28e-f show event, the Medical Exampler marking at	by Funerai	11. Marital Status  1 Never Married 2 Marria 3 Widowed 4 Divorced	I If Yes Give	No XNo		Was Dece f Yes, spe 1 ☐ Yes		lispanic Orig an, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White Specify:		
15-0036	"nature	eted		t's Education st grade completed)		16a. Dece	kind of we	ork done	durina most	t of worki	n <i>g</i>	16b. K	ind of Business/	Industry	
2121	d within giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		lome						Home	2	
aryland 2121	b d la b	To Be (	17. Father's Name (First, Middle, Robert Hall	Last)					18. Mothe Omn	er's Name NIE	Balla	e, <i>Maid</i> en rd	Sumame)		
≥	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relations Joseph Adams			19b. Mailir 907	_				xon H		or Town, State, 2 MD 207		
more,	Pages 1 and of He out: If Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta	te i	Place of Dispo cemetery, crer	natory or	other plac			ate		ocation - City or		
altin	permit. Pages. Department of Importent: If Ite ony injury or of	1	4 □Donation 5 □Other (S		Tr 0094	_						400	ldorf, DME,P.A		and
ñ	Dep Imp		1 David (	- Chal		111	ll S	t. N	Mary'	's A	ve. L	a Pl	lata,MI	20646	5
	Dhualalan		Approximate shock, or heart failure. List only one cause on each line.  Approximate shock, or heart failure. List only one cause on each line.  Approximate shock, or heart failure. List only one cause on each line.  Approximate shock, or heart failure. List only one cause on each line.  Approximate shock, or heart failure. List only one cause on each line.  Onset and Death session or condition.												veen
r.	Physician /Medical Examiner		disease or condition resulting in death)	a. Small	as a consec	quence of):	un	g	CA	m C	er"			lomo	nths
35		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (u.	as a Cuñsec	quence of).									
_°	certificate be executed Iding physicien and Ise as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a consec	quence of);									
8760	icate be execute physicien and s the burial-trans	dicai		d											
m m	e death certifii he attending p ied for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Feta	aideath 3 [	Ectopic p Other (s)		,				23d. Date of deli Month		ear
O.	res that the de igned by the is be detached		9 ☐ Unknown L  Part II. Other significant condition			sulting in the ur	nderlying (	ause givi	en in Part I.		23e. Did	tobacco u	use contribute to	the cause of de	eath?
ords	w requires been sign should be	ted by									10	Yes 2	□No 3, Pro	obabiy 4 🗆 U	nknown
al Records,	The larate has	Completed											prior to death?	topsy findings a completion of ca 2 No	vailable use of
Vital	sician: 's certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ationt 2	ER/Outpatien	2 O	Othe			(Check only		a [] Out (0		
Division of	or Attending Physician: ifter death. Director: After this certific in by the funeral director.	$\vdash$	27. Magner of Death  12 Natural 5 Pendin  2 Accident investig	28a. Date of Ir (Month, L		28b. Time of Injury		28c. Injury Work	4 🔲 NUI	2	28d. Describe		6 □Other (Spec y occurred	ary)	
DIVIS	el or Attendi s after death. Il Director: A sd in by the fu	Certification:	3 Suicide 6 Could a determ	ined   286, Place 01	Injury - At h etc. (Specia	ome, farm, str fy)	eet, factor	y, office		2	28f. Location ( City or To		d Number or Ru )	ral Route Numb	<i>1⊕1</i> ,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical (	29a. Certifier Check only one) Certifyin 2 Medical	g Physicien: To the be Examiner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred estigation	at the time, in my of	ne, date and pinion, deat	d place, a	and due to the ad at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complex	Me	29b. Signature and title of certifier						e number				te signed (Month		
0			30. Name and address of person	who completed cause o	f death (Iter	n 23a) (Type	Print)	141	627	+6		Sep	tember	12,2	2006
1	812		/	M. ASHRA	f M	EELU	M	5		WF	1LD01	3F	tember 206	03	
	Sta Registr		31. Date filed (Month, Pay, Year) SEP 1	3 2006 32. P	strar's Signa	ature	book	,							

06-06981 Judith Marie Bailey

#### Please Type or Print in Black Indelible Ink

udith Marie Bailey	1- For State Certifica	ate of Death	Reg No 2006 3049
Physician/ Medical Examinë			Date of Death Month Day Year September 15, 2006  3. Time of Death 1955 hrs
The state of the s	4a Facility Name (if not institution, give street and number)  Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederick	4c. County of Death Calvert
Funeral Director	5. Social Security Number 6 Sex 7 Age (In yrs last birth 215-92-5045 1 M 2 X F 44		8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Wash., D.C
any	Usual Residence of Decedent           10a State         10b. County         10c. City, Town	or Location	10d. Inside City Limits
* .	Maryland Calvert	St. Leonard	1 Yes 2 X No
uh the Maryland 23a or 28a-f sho notified at once		10f. Zip Code 20685	10g Citizen of What Country? USA
er death wi , or items r must be		Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ric     Yes 2 X No specify:	can, etc.) White, etc.
ours afta atural" xamine ed by	lor Dates:	Decedent's Usual Occupation (Give kind of work	
C1 3 - 7	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retired  Never Worked	n/a
	James Michael Bailey	Mary	irst, Middle, Maiden Surname) Boileau
	Regan Bailey/sister		al Route Number, City or Town, State, Zip Code) Shady Side, MD 20764
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	1 V Burial 2 Cremation 3 Removal from State cremate	ory or other place) Creek Cemeter y 9/2	20c. Location - City or Town, State 3/06 Washington, D.C.
Baltimo permit Page Department of Important; injury or oth	21. Signature of Funeral Service Licensee  Llacky A. Sewell		Rd.Prince Fred.,MD20678
Physician /Medical xaminer		nt enter the mode of dying, such as cardiac or respectified neurodevelormenta	Between Onset and
	Sequentially list conditions.		
red Insit Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):		
s execute sian and rial - tran		ME, G861,11/16/06 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transing chical Certification: To Be Completed by Physician/Medical Especial Certification: To Be Completed by Physician/Medical Especial Certification: To Be Completed by Physician/Medical Especial Certification: To Be Completed by Physician Certification: To Be Completed by Physician Certification: To Be Completed by Physician Certification (Certification) and Certification (Certification)	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Boy he death y the att	1 Yes 2 No 9 V Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
i, P.O. Bries that the designed by the be detached by D.	â ·	; in the underlying cause given in Patti.	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require rs after death al Director: After this certificate has been sighed in by the funeral director, page 2 should be artification: To Be Completed			24a. Was an autopsy performed?  1 Ves 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No 2000 No 200
ital Reisian: The scertificate rector, page		26 Place of Death (Check only	
n of Viding Physical After this stuneral direction: To	27 Manager of Deeth 290 Date of Injury 290	atputient 5 507 4 14dishig h	dome 5 Residence 6 Other:
Division o spital or Attending hours after death aneral Director: After in by the fune Centification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)		of. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours To the Funeral completely filled	1 /98 Certifier		
D. W. C. C. C. C. C. C. C. C. C. C. C. C. C.	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d Date signed (Month, Day, Year) September 16, 2006
	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21201	
State Registra		Backer	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Florence Elizabeth Bennington September 9, 2006 5:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Asbury-Solomons Health Care Center Solomons Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2X F Director 567-07-7521 88 28, 1917 Washington Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exeminer must be nutified at 1 Yes 2X No Directo Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 11750 Asbury Circle Apt. #113 20688 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: White 3√ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Housewife Homemaker Pages 1 and 2 should be filed w treent of Health and Mental Hygie trant: if item 27 is marked other t jury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick D. Gross Harriett E. Spaugler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Short (Daughter) 6084 Macs Hollow Rd., Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: if sny injury or once. 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 9/11/2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A, 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CUNICINO 572013 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physicien and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown been si 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? wten Corner certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funerel Director: After this cartific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4631r type and address of person who completed cause of death (Item 23a) (Type, Print) to 110 31. Date filed (Month, Day, Year) 32. Registres Signature State 2006 ▶ Registrar

State of Maryland / Department of Health and Mental Hygien 2006 30495 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** a: 28AM Margaret Jean Bowers September 12 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital

5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) Hagerstown
1 Year | If Under 24 Hrs. Washington

9. Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 TYF 73 Director 214-32-2501 August 22 1933 Pennsylvania 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or then "natural", or items 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes X ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13411 Marsh Pike 21742 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) hours after 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 ient of Heelth and Mental Hygiene.
nt: If Item 27 ie marked other then "n ry or other traumatic event within Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Thomas W. Verner Jean Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13920 Coachians Circle Cermantown Maryland 20874 of Disposition (Name of Date 20c. Location - City or Town, State Linda B. Eckrich (daughter) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Importent: If eny injury or once. Rest Haven Cemetery | Sept 15 06 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Fuenral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the 1 ease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) STROILE **Physician** well /Medical Due to (or as a consequence of) Examiner Month IVER PALLURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 2-3 wales ENCO HITH burial-tran Due to (or as a consequence of). Physician/Medical use as the attending for use as tF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) o detached 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ ALCO HOL 3 Probably 4 Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 1 ☐ Yes 2 No Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA o this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: O Hospital or Attending 1 Natural Injun 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the Divisi 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 046561 Sept. 12. 2006 Redwim1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATTWA ROAD HAGENSTOWN 1190 MD 21740 13H-4 31. Date filed (Month, Day, Year) 3 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For	State of Maryland	/ Depa	artment of	Health a		ntal Hygie	ene		00100
		_	1 - State Registrar		Cei	rtificate o	f Death			. No 20	Ub	30496
	Physici	an	Decedent's Name (First, Middle, Last)     Hayes Bennett Ban					2	Date of Death Month	Day	Year	3. Time of Death
1	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town	, or Location of	f Death	09	09 2 4c. County	006 of Death	8:57A <sup>M</sup>
	Lxuiiii		Fort Washington H			Fort W	ashing	ton		Princ		orges
	Funeral		5. Social Security Number 6. Sex	M 2□F	t birthday) Yrs.	If Under 1 Yea	ar If Under 2	Min. 8	. Date of Birth (Month, Day, Y			lace (State or Foreign
	Director		225-03-4438	94	115.				07-21-	1912	VA	
	how	_	10a. State 10b. County	10c. City,	Town or Lo	cation					1	Od. Inside City Limits
	8a-f s	ecto	MD Prince G	eorges Fort	Wash	ington						1 □Yes 2 No
	with t	Ē	10e. Street and Number	. 1		10f. Zip Code			100	. Citizen of V	What Cour	ntry?
	death ms 23	nera	11501 Riverview R	12. Was Decedent Ever in U.S.	13. \	Was Decedent of f Yes, specify C	20744 f Hispanic Orig	jin? (Specif	y Yes or No-			an Indian,
9	after or Ita	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		t Yes, specify Ci 1 ☐ Yes 2 ☑ N		, Puerto Rio	can, etc.)	Specify	k, White,	etc. .ack
Ö	hours lural',	d b	3 ☑ Widowed 4 □ Divorced	Year or Dates:					146			
7	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show ha Medical Examihar must be notified at	plete	15. Decedent's Educity only highest grade  Elementary/Secondary (0-12)	e completed)	(Give	lent's Usual Occ kind of work dor DO NOT use reti	ne durina most	of working	16	b. Kind of Bu	ısıness/Ind	dustry
Maryland 21215-0036	ar tha	Completed	unknown	College (1-4or 5+)	Cra	ne Oper	ator		I	aper (	Corp	Mead
n	ba file Ital Hy Id oth evant	Be	17. Father's Name (First, Middle, Last)					•	First, Middle, Ma	iden Suman	10)	
<u> </u>	hould d Mer marks martic	2	William Banks  19a. Informant's Name/Relationship (Ty)	one Print)	19h Mailin	n Addrage (Stra			Perkins Route Number, (	ity or Tour	State Zin	Codal
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or frams 23a or 28a-f show any injury or other traumatic evant, the Medical Examinat must be notified at ance.		James W. Banks/So						Spring.			Code
altimore,	es 1 a of Hea fitam rotha		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other p	olace)	Date		c. Location -		wn, State
Ē	Page ment tant: If		XXBurial 2 ☐ Cremation 3 ☐R '4 ☐ Donation 5 ☐ Other (Specify)	enioval nom State	st Hi	11 Buri	al Pk 9	9-14-2	2006 Ly	nchbui	cg. V	A
Ball	permit Depart Import any in		21. Signature of Funeral Service License	эe	22	. Name and Add			all's F			
			23a. Part1. Enter the disease, or compli	ications that caused the death.	Do not ente	er the mode of d					ash.	DC 20011 Approximate
W.	Physician		shock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.  Pneumonia			, ,		,	,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequer	nce of):							
	Examiner	_	Sequentially list conditions,	Dehydration  Due to (or as a consequer								
	itad nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unique to impury	Alzheimers	nce or):							
oʻ	execu an and rial-tra	Еха	that initiated events cresulting in death) Last	Due to (or as a consequer	nce of):							
8760,	ate be executad hysician and the burial-transit	lcal	ď	Dementia								
39 ×	death certificate be executad e attending physician and od for use as the burial-transit	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnance	v							
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3	Ectopic pregnar Other (specify)				23d. Dat	e of delive nth	Day Year
<u>о</u> .	at the de by the a tached	hysi	9 Unknown	9□ Unknown								
	as the gnad be de	by	Part II. Other significant conditions con	tributing to death but not resulting	ng in the ur	nderlying cause	given in Part I.					e cause of death?
ord	w raquir been si should I	eted										ably 4 Unknown
Records,	The law ate has l page 2 s	Completed							24a. Was an autopsy performe		Vere autor prior to con feath?	psy findings available apletion of cause of
	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical				26 Place	of Death (C	1 ☐ Yes <b>2</b> € Check only one)	No 1	Yes	2 No
<u> </u>	8 5	To B	examiner? 1 ☐ Yes 2 ☑No	lospital: 1 ☑ Inpatient 2 ☐ EP	VOutpatien	t 3 DOA	N		5 Residence	e 6 Oth	er (Specify	)
n 0	ding Phy h. After this funeral c		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. In			I. Describe how	injury occurr	ed	
Division of Vital	deat deat ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	e. farm. stre		□Yes 2□N		. Location (Stre	at and Numb	er or Rura	l Route Number,
2	al or At s after d il Diraci id in by	Serti	4 Homicide determined	building, etc. (Specify)		,			City or Town,			
	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier 1 🔀 Certifying Phys	sician: To the best of my knowle ner: On the basis of examination	edge, death	occurred at the	time, date and	place, and	due to the caus	e(s) and ma	nner as st	ated.
	To tha H within 24 To tha F complete	Medical	one)	and manner stated.			nse number					
	To To		29b. Signature and title of certifier	M						Date signed		-uj, 1991)
)	(a)		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, I		182			09/12/	2006	
_	(4)		Felton Anderson, 9	9400 Livingston	Rd,	#350, H	t. Wasl	hingt	on, MD	20744		
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 1 3 2006	32. Registrar's Signatur	had	1						
	1109,511		DEL I O TOOR	1								

06-06936 William Buck

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006

		1- For State Registrar		Certific	cate of	Death			Reg. No.	21	700	3049
Physici Medical Exam	an/											Time of Death 1600 hrs
And the second		4a. Facility Name (if not institution University Hospital	on, give street and n	umber)	4	b City, Town, or Lo Baltimore	ocation of Death		4c.	County of	Death	
Funeral Director		5. Social Security Number	6 Sex	7. Age (In yrs. last bi	•	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8 Date of B		F	Foreign	
		521-39-7490 Usual Residence of Decedent	I X WI Z F	30	Yrs			Dec.	22,19	75 []	Penns	ylvania
any		10a. State 10b. County		10c. City, Town	n or Locatio	on .					10d	Inside City Limits
Varyland 28a-f show any d at once.	tor		lerick	Brunsw	ick				_			Yes 2 X No
or	Director	10e. Street and Number  123 Florida Ave	enue			10f. Zip Code 2171			Unit		tates	
eath with th items 23a ust be noti	Funeral	11. Marital Status 1 X Never Married 2 M		cedent Ever in U.S orces?	13. Was	Decedent of Hispa s, specify Cuban, N	anic Origin? ( Spe Mexican, Puerto F	ecify Yes or N Rican, etc.)	lo- 1	14. Race - A White, e		Indian, Black,
after de al", or	by Fi		orced If Yes, Give Ye or Dates.	ar	1	Yes 2X No	specify:		s	Specify:	Whi	ite
136 hin 72 hours after e than "natural", edical Examiner	ted t	15. Decedent's Education (Spe	cify only highest gra			s Usual Occupation st of working life. D			16b. Kır	nd of Busir	ness/Indus	itry
0036 within 72 iene ier than ⁴	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	P1 <sub>1</sub>	ımber				Plumb:	ina	
P ed by the ball		17. Father's Name (First, Middle,	Last)		111		Mother's Name (	First, Middle,	, Maiden S	urname)	TIIR	
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene taut: If item 27 is marked other than or other traumatic event, the Medica		Thomas Boland				В	Brenda Bo	back				
MD 2  rd 2 should the and M 27 is m an artic of a must	٦ ا	19a. Informant's Name/Relations		10		Address (Street a						
e, M and 2 Health item 2 traum		Brenda Boland/M 20a. Method of Disposition	other	20b. Place	of Disposit	Lorida Av	tenue, Bri	<u>INSW1C</u> Date			nd 21 Dity or Town	
nore		1 Burial 2 X Cremation		TOTH State	atory or othe			/10/06		1 .	1 10	
Baltimore, permit Pages 1 at Department of He Important: If ite injury or other it		4 Donation 5 Other Sp 21 grature of Funeral Service			22. Na	Cremator	f Facility					
11621 Opossumtown Pike, Fred										ick N	Mary1	and21702
Physician /Medical		failure. List only one cause	on each line				uch as cardiac or	respiratory a	rrest, shoc	k, or heart		etween Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)		cations of li	ver di	sease						Death
	L	Sequentially list conditions,	b									
	nine	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated		a consequence of):								
sted d ansit	Examiner	events resulting in death) Last	Due to (or as	a consequence of)								
Sox 68760, death certificate be executed re attending physician and I for use as the burial - transit	n/Medical	X UNPENDED	X AMENDED	item#4b,23	a,PII,	27, perME, g8	360, 10/5/	06 TT				
<b>∞</b> ± ∞ s	n/Me	IF FEMALE: 23b Was decedent pregnant in th		outcome of pregnancy	/ 2 Feta	al death 3	Ectopic pregnan	icv		Date of de Month	elivery Day	Year
Box 61 be death cert the attendir	Physicia	past 12 months?	roown I	nant at time of death		er (Specify)		,	28		Suy	100.
the	Phy	Part II. Other significant condit	9 Olikii		ng in the ur	iderlying cause give	en in Part I.	23e Did	tobacco us	se contribu	ute to the c	ause of death?
Records, P.O. The law requires that the cate has been signed by page 2 should be detach	d b	Chronic drug u						1 Ye	es 2	No 3	Probably	4 🗸 Unknown
of Vital Records, ng Physician: The law requir Mer this certificate has been s meral director, page 2 should	Completed						•	24a Was				y findings available letion of cause of
The law ate has age 2 s	omp					·			ormed?	dea	ath? ✔ Yes	2 No
tal Recian: The certificate ector, page	BeC	25. Was case referred to medica examiner?					f Death (Check or					
Vit	2	1 ✓ Yes 2 No	Hospital: 1		Outpatient				Residence		Other:	
C # #	ion	27. Manner of Death  1 X Natural 5 Pend		e of Injury h, Day,Year)	Time of In		at Work?	28d. Describe	how injury	y occurred	1	
Division ral or Attendi rs after death at Director: A	ertification		stigation 28e Plac	ce of Injury - At home, t	farm, street	, factory, office buil	Iding, etc. 2			d Number	or Rural Ro	oute Number, City
Div pital o ours af	Certi	4 Homicide deter	rmined (Specify)	)			di di	or Town,	State)			
Division  To the Hospital or Attenuable to the Functal Director: To the Functal Director: completely filled in by the	Medical	(	miner:On the basis	st of my knowledge, de of examination and/or								use(s)
	Me	29b. Signature and title of certifie	and manner :	stated		29c License r	number		29d Da	ate signed	(Month, D	Day, Year)
		Caroly	tall	av		O.C.M	.E.		Septe	ember 1	15, 2006	
7		30 Name and address of person			D. 6	tt D !!!	- MD 0:00:					
			sistant Medical		Penn S	treet, Baltimor	e, MD 21201					
S Regis	tate trar	31. Date filed (MoStEDy, Yar)	ZUUB 2	gistrar's Signatur	Agent	We .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene 0.0 C

			1 - For State Registrar	State	or mary	апа / Бер Се	rtificate	of Dea	ath	vientai m	ygien Rag. N	2005	30498
	Physic	an	Decedent's Name (First, M.							2. Date of D	eath	av Year	3. Time of Death
	/Medi		Violet Louise	Bradbury						Septem	ber	7, 2006	8:21 P M
Jan Sand	Exami	ner	4a. Facility Name (If not instit				4b. City, T	own, or Loca	tion of Death	1	4	c. County of Deat	h
			Glade Valley 5. Social Security Number					kersvi				Fred	erick
	Funeral Director		405-26-0934 Usual Residence of Deceder	6. Sex 1 ☐ M 2 🔯 I		79 Yrs.			Inder 24 Hrs. Burs Min.	8. Date of B (Month, D June	lth Yea	1927 Ken	hplace (State or Foreign untry) tucky
	land w		10a. State 10b. Co		10c.	City, Town or L	ocation						10d. Inside City Limits
	Mary -feh	ţ	Maryland Fr	ederick		Walker	sville	<u>.</u>					1 Yes 2 No
	h the	irec	10e. Street and Number				10f. Zip C				10g. C	Citizen of What Co	untry?
	23a c	Funeral Director	56 West Fred	erick Stre	eet		2	21793				United S	tates
	r dea	ner	11. Marital Status	12. Was C	ecedent Ever if	n U.S. 13.	Was Decede	nt of Hispanie	ic Origin? (Sp	pecify Yes or No Rican, etc.)		14. Race - Ame Black, White	rican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itema 23a or 28a-f show any highry or other treumatic event, the Medical Examinar must be notified at once.	<u>چ</u>	1 ☐ Never Married 2 ☐ 3 🔀 Widowed 4 ☐ Divo	Married 1 ☐ Ye If Yes,	s 2 X No		1 ☐ Yes 2			7 110411, 515.,			hite
5-0	72 h	Completed	15. Dece (Specify only hi	edent's Education ighest grade complete	ed)		dent's Usual kind of work		most of wor	kina	16b.	Kind of Business/	Industry
121	vithin ne.	ig i	Elementary/Secondary (0-		e (1-4or 5+)	life.	DO NOT use	retired)		9			
	iled v tygie her ti		10 17. Father's Name (First, Mid	Idle ( act)		Scho	ol Bus			- (P** - 1.41.1.1)		ounty Gor	vernment
Maryland	ntai h	Be	(unobtainable							ne (First, Middle			
Ž	hould d Me mark matic	2	19a. Informant's Name/Relat			10h Maili	Address /			inable)			
S	ith an It	6	Gloria Bradbu		r-in-la							or Town, State, 2 21769	ip Code)
	Hear Hear tem	1 8	20a. Method of Disposition	J. 7		b. Place of Dispo	osition (Name	of	1	Date	_	Location - City or	Town, State
9	Pages ent of nt: If i		1 ⊠ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe		om State	cemetery, cre Par	maiory or oth klawn	er place)	_	t. 11,	-	1 477	
Baltimore,	artm oortar injui		21. Signature of Funeral Sen		-	Memoria	2 Name and	Addrage of E	Cooling	005			Maryland
ä	Department of the partment of		1/1	5/		R   9	esthav 501 Ca	en Fun toctin	neral : n Mtn.	Service Hwv. F	s, S	Skkot Coc erick, M	ly P.A.
			23a. Part1. Enter the disease shock, or heart failure.	o complications the	at caused the d	eath. Do not en	ter the mode	of dying, such	h as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	•		Heart F	ailuro						Onset and Death
	/Medical		disease or condition resulting in death)  a. Congestive Heart Failure  Due to (or as a consequence of):										
	Examiner		Sequentially list conditions.	<sub>b.</sub> Dias	tolic D	ysfunct	ion	_			_		
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as a cons	sequence or):							
	and P-tran	Examiner	that initiated events resulting in death) Last	c. H e	rtensio	n							
60,	icate be executed physician and s the burial-transit			500	to (or as a cons	soquence or).							
68760,	rificate be executed ng physician and as the burial-transit	Aedicai		d									
Вох	certii nding use a	NA.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of pre	gnancy						23d. Date of deli	
-	death cert a attendin d for use	cia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pre	re birth 2□F egnant at time o		⊒Ectopic preg ⊒ Other (spec				Ĭ	Month Month	Day Year
P.0	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	Physician/	9 □ Unknown	9□Un	known								
	es tha igned be det	by P	Part II. Other significant con	ditions contributing to	o death but not	resulting in the u	nderlying cau	se given in P	Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ğ	en sig		<u>Diabetes Mell</u>	itus, Obst	ructive	Sleep	Apnea,			1 🗆	Yes 2	2⊠No 3□Pro	bably 4 Unknown
ည	faw requas been 2 shoul	piet	Previous CVA,	Coronary	Artery	Disease				24a. Was		24b. Were au	lopsy findings available
<u> </u>		Completed								auto perf	ormed?	death?	ompletion of cause of 2 ☐ No
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to med examiner?	tical				26. P	Place of Deat	h Check only			
<u>&gt;</u>	Physic this co	ဥ	1 ☐ Yes 2 ☑ No			ER/Outpatier		Other: 4 🔯	Nursing Ho	me 5□Res	idence	6 □Other (Spec	ify)
Ē		ii o	27. Manner of Death 1 🛣 Natural 5 🗆 Pe		ite of Injury Ionth, Day Year	28b. Time o Injury		. Injury at Work?		28d. Describe	how inju	ury occurred	
Sig	or Attending ter death. Irector: After by the fune	cat		estigation uld not be			М	1 ☐ Yes 2	2 □No				
Division of Vital Records,	s after or All Direct of Direct of Direct of Direct of the by	Certification:		armined 288. Pla	ace of Injury - A ilding, etc. <i>(Spe</i>	t home, farm, str ec <i>ify)</i>	eet, factory, c	office		City or To	Street a wn, Stat	.nd Number or Ru le)	ral Route Number,
	To the Hospital or, within 24 hours after To the Funerel Direcompletely filled in L	edicai	29a. Certifier 1	fying Physician: To cal Examinar: On the and m	the best of my i e basis of exam anner stated.	knowledge, death ination and/or in	h occurred at vestigation, in	the time, date my opinion,	e and place, death occur	and due to the red at the time,	cause(s	s) and manner as ad place, and due	stated. to the cause(s)
	To ti To ti Comp	×	29b. Signature and title of ce	tifier V		,	29c. L	icense numb	ber		29d. Da	ate signed (Month	, Day, Year)
)	1.1		I my	· In	W	12	D	21944			Se	pt. 8, 2	006
	4		30. Name and address of per-	son who completed ca	ause of death (I	tem 23a) (Type,	Print)					, _	
			James D. Gris	som, M.D.	1475 T	aney Ave	e., Ste	204	, Fred	erick,	MD	21702	
	Sta Registr		31. Date filed (Month, Day, You SEP	1 2006 32	gistrar's Sig	gnature	Coole						

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of H	lealth an Death	d Mental Hy	giene	006	304	99		
	Dhueisi		1. Decedent's Name (First, Middle, L	Last)					2. Date of De	nath Day	Year	3. Time of 0	Death		
	Physici /Medio		Cozette			Barbo	our		Septer	nber 8	2006	2300	М		
Belginson	Examir	er	4a. Facility Name (If not institution, g		nber)		4b. City, Town, or		Death		ity of Death				
			45 Franklin St				Annapo		I lea		ne Ar				
	Funeral			.Sex 1 □ M 2 <b>XCX</b> F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			th 19, Year) 28 1912		olace (State or ntry)	Foreign		
	Director		489-14-5118 Usual Residence of Decedent		94				July 2	28 1912	Ten	nessee			
	/land		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City	y Limits		
	Man Ha	to	MD Anne	Arundel		Annapo	olis					1 🔀 Yes	2 🗌 No		
	r 28g	Director	10e. Street and Number			-	10f. Zip Code			10g. Citizen o	f What Cou	ntry?			
	15 wit	a D	45 Franklin Sti	reet			21	401			USA				
	dea E	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	J.S. 13.	Was Decedent of Hi	ispanic Origin	? (Specify Yes or No Juerto Rican, etc.)	)- 14. R	ace - Americ				
9	or It	臣	1 ☐ Never Married 2 ☐ Married		2 XNo			Specify:	2010 1 10211, 010.7	Spec		White			
ë	within 72 hours after death with the Maryland ene. Then "netural", or Items 23e or 28e-f ehow the Medical Exeminer must be notified at	d by	3 Widowed 4 □ Divorced	Year or D	ates:										
,	n 72	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16b. Kind of	Business/In	dustry			
7	withing withing the n	μď	Elementary/Secondary (0-12)	College (1	-4or 5+)	Homer		7		Orm	Home				
0 0	Hygi Hygi Int,		17. Father's Name (First, Middle, La.	st)		Homer	daker	18. Mother's	Name (First, Middle						
an	d be ental ked c	To Be	Wesley T. Hawks	3					e Strain						
Maryland 21215-0036	nd M mar mat	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a			Number, City or Town, State, Zip Code)					
Ž	alth a 27 to 127 to		Sandra K. Marie	e (Daught	er)	179 1	Ouke of G	louces	ter, Anna	olis,	MD 21	401			
Baltimore,	1 Burial 2 ACremation 3 Removal from State										20c. Location - City or Town, State				
Ĕ	1 Burial 2 Micromation 3 Removal from State 4 Donation 5 Other (Specify)  Metro Crematory  9-11-200									Balti	more,	MD			
a	porti		21. Signature of Funeral Service Lic	gns go		22	Name and Address	s of Facility	al Home I						
<u> </u>	21. Signature of Funeral Service Liensee  22. Name and Address of Facility Hardesty Funeral Home, 12 Ridgely Avenue, Anna  23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory										MD 214	401			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cally one cause on e	aused the dea ach line.	th. Do not ent	er the mode of dying	g, such as car	rdiac or respiratory a	rrest,		Approximate Interval Betw	/een		
<sub>p</sub> F	Physician		Immediate Cause (Final disease or condition	a	Caro	1-9/x	Artez	c:G	Chit			Onset and Do	Satu S		
	/Medical Examiner		resulting in death)	Due to (	or as a consec	quence of		,							
		76	Sequentially list conditions,	b. — Phasa tru f	ur as a consec	waston offi									
	ted nsit	nlne	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	240 13 (	01 45 4 0011560	<b>146</b> 1100 01).									
	axecu nand al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a consec	quence of):					-				
8760,	cate be executed physicien and the burial-transit	dicai		L d											
9	tificat g phy es th	led													
Box	leath certifica attending pt for use es t	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnirth 2 Fets		Ectopic pregnancy			23d. E	ate of delive	ery			
0	ed for	Physician/Me	in the past 12 months? 1 Yes 2 No		ant at time of c		Other (specify)				fonth	Day Ye	ear		
<u>Р</u>	at the de t by the s etached	Phy	9 Unknown												
ŝ	res that signed t	þ	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the ur	nderlying cause give	en in Part I.		obacco use cc Yes 2 ⊠No		ne cause of de pably 4 ⊟Ur			
9	w require been si should I	Completed		-					-   ''	Tes Zazino	3 [] FIOD	ably 4 🗆 01			
Division of Vital Records,	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopens? 1   1   2   Fetal death   3   Ectopic pregnancy   23d. Date   Mont   2   Fetal death   3   Ectopic pregnancy   3   Mont   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown   2   Mont   2   Mont   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   2   Mont   2   Mont   3   Mont   2   Mont   3								were auto prior to co death?	psy findings at mpletion of car	vailable use of				
<u>_</u>										2 No	1 Yes	2□ No			
₹ :	sician: certific irector,	) Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{TMO} \)	Hospital:		15510	Othe		Death (Check only o						
ō :	Attending Physician: r death. sctor: After this certific. by the funeral director.	To	27. Manner of Death	<del></del>	npatient 2 of Injury h, Day Year)	ER/Outpatien 28b. Time of	1 30 DOA	4   1401511	ng Home 5 Resident		ther (Specif	y)			
<u>8</u>	nding t th. :: After e funer	ig ig	1 █Natural 5 ☐ Pending 2 ☐ Accident investigati		h, Day Year)	Injury		k? Yes 2∐No							
NS :	or Atten after deat Director: in by the	Hick	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place	of Injury - At h	ome, farm, stre	eet, factory, office		28f. Location (		nber or Rura	l Route Numb	oer,		
ā .	s after s after al Dire ed in by	Certification:	4 Tromicido	Buildii	ig, etc. (Specia	<b>'y</b> ')			City or Tox	wn, Siale)					
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physicien: To the aminer: On the ba and mann	isis of examina	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and pointon, death o	lace, and due to the occurred at the time,	cause(s) and r date and place	nanner as s	tated. the cause(s)			
	vithin 2 To the complet	Mec	29b. Signature and title of certifier	A A			29c. License	number		29d. Date sign	ed (Month.	Day, Year)			
	- 3 ⊢ ŏ		MatAll	alx			-	1819		9/11/2		-			
-	,		30. Name and address of person wh	o completed caus	e of death (Iter	n 23a) (Type				,,,					
	10		Matthew J. Mal					201, A	nnapolis,	MD 214	01				
	Sta		31. Date filed (Month, Day, Year)	32.	gistrar's Signa		0 -				·				
	Registr	ar	<b>SE</b> P 11	2006		AS A	reke								

			For State	State of Mar		artment of Healt	th and Mental H	2001	30500
ı	Physic	ian	Registrar  1. Decedent's Name (First, Middle, La:	st)	Cel	incate of Dea	2. Date of D	Reg. No. Death Day Year	3. Time of Death
-	/Medi	cal	Emma Lee Bratten  4a. Facility Name (If not institution, giv.)	etreet and number		4h Cihi Taum ad Land	Septe		
	Exami Funeral Director	ner	Berlin Nursing & ] 5. Social Security Number 6. S	Rehabilitat	In yrs. last birthday)		nder 24 Hrs. 8. Date of B	Day, Year) Co	-
	yland		10a. State 10b. County	1	0c. City, Town or Lo	cation			10d. Inside City Limits
	Man B-f eh	ţċ	MD Worcest	ter	Berlin				1⊠Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	ountry?
	ath w	rail	10220 Henry Rd.			21811		USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "netural; or items 23s or 28s-1 show other traumatic event, the Medical Examinat must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	Yes, specify Cuban, Mer	c Origin? (Specify Yes or N xican, Puerto Rican, etc.) ecify:	Black, Whit	
15-(	in 72 h n netu	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give I	ent's Usual Occupation kind of work done during OO NOT use retired)	most of working	16b. Kind of Business	Industry
212	filed within Hygiene. other than "I	шо	Elementary/Secondary (0-12)  9th	College (1-4or 5+)		Housekeepe	er	Hotel	
	al Hygir t other	Be C	17. Father's Name (First, Middle, Last)			*	Nother's Name (First, Middl		
yla	2 should be and Mental is marked o	2	Elbert Beasley				mecia Willia		
Maryland	12 sh h and 7 is m iraum		19a. Informant's Name/Relationship (7	•			umber or Rural Route Num		Zip Code)
0	1 and 2 Health tem 27 l		Shirley Purnell/da 20a. Method of Disposition		10220 20b. Place of Dispos	Henry Rd.,	Berlin, MD	21811 20c. Location - City or	Town State
Baltimore,	permit. Pages Department of I Important: If Ite any injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	i ioiniovai iioini otato	20b. Place of Dispos cemetery, crem				
) <u>≢</u>	mit. Foortan		21. Signature of Funeral Service Licen		St. Paul's	Name and Address of Fa	9/13/2006	Berlin, MI	)
ď	Depa Impo	b di	Talanap	Walson	Le	wis N. Wats	on Funeral H , Salisbury,	ome	
,			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	e death. Do not ente	r the mode of dying, such	h as cardiac or respiratory	arrest,	Approximate Interval Between
	Cate be executed by sician buysician and buysician and site parial-transit in parial-transit.	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to for as a c  Due to (or as a c  Due to (or as a c  d.	onsequence of);	Footag :	ed lasce	wina	Onset and Death
. Box (	death certif e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3 1	Ectopic pregnancy Other (specify)		23d. Date of deli Month	ivery Day Year
	law requires that the es been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the un	derlying cause given in Pa	art I. 23e. Did	tobacco use contribute to	the cause of death?
ord	requir een si ould I	ted					10	Yes 2 □ No 3 □ Pro	obably 4 Hoknown
œ	The lar ate hes page 2	e Completed	25 Was and a standard				1 ☐ Yes	ormed?   death? 2 1 Yes	topsy findings available completion of cause of 2 ☐ No
f Vital	ysicle is cert directi	ToB	25. Was case referred to medical examiner?  1 Yes 2	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	104	lace of Death   Check only		.4.1
o c	ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury at Work?		how injury occurred	iry)
Sio	ttsndir death. :tor: Af r the fu	catic	2 Accident S Pending investigation	(Monin, Day 7	an, injury	M 1 ☐ Yes 2	2 □No		
Division	To the Hospital or Attending Physician: within 24 hours after dealt within 24 hours To the Funerei Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	Specify)	,,	City or To	'Street and Number or Ru wn, State)	
	• Hosp 24 hou • Fune etely fi	Medical	29a. Certifier Certifying Phy (Check only one) Medical Exemi	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inve	occurred at the time, date estigation, in my opinion,	e and place, and due to the death occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To the within To the To the Complex Co	Me	29b. Signature and title of certifier  30. Na and address of pesson who co	completed cause of death	(Item 23a) (Type P	29c. License numb	3769	29d. Date signed (Month	Day, Year)
	Pa		Nillolos Dop	dula,	D 121	9 Exeste	el Haken	- De	19944
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,	J	/	
DHM	H 17 Rev 1/20		SEP 1 2 2	Wood Marie	I A	rade			
J. 11V				•	ORIGIN	AL			